Champaign County Board for Care and Treatment of Persons with a Developmental Disability, referred to as Champaign County Developmental Disabilities Board (CCDDB)
Meeting Agenda
Wednesday, March 25, 2026, 9:00 AM

This meeting will be held in person in the Shields-Carter Room of the Scott M. Bennett Administrative Center, 102 E. Main St., Urbana, IL 61801. Members of the public may attend in person or virtually: *https://us02web.zoom.us/j/81559124557* Meeting ID: 815 5912 4557

I. **Call to order**

II. **Roll call**

III. **Approval of Agenda***

IV. **Schedules and Timeline**

For information only are the CCDDB 2026 Meeting Schedule posted here (https://champaigncountyil.gov/MHBDDB/pdfs/ddbmeetsched2026.pdf),

Champaign County Mental Health Board (CCMHB) 2026 Meeting Schedule posted here (https://champaigncountyil.gov/MHBDDB/pdfs/mhbmeetsched2026.pdf), and

PY27 Allocation Timeline or "CCDDB Important Dates" posted among public documents here (https://ccmhddbrds.org).

V. **CCDDB Acronyms and Glossary**

For information, an updated glossary is posted here (https://www.champaigncountyil.gov/MHBDDB/PDFS/DDB%20Glossary%202024.pdf).

VI. **Citizen Input/Public Participation - See below for details.****

VII. **Chairperson's Comments – Dr. Anne Robin**

VIII. **Executive Director's Comments – Lynn Canfield**

IX. Approval of CCDDB Board Meeting Minutes (pages 5-13)*

Action is requested to approve the minutes of the CCDDB's January 28, 2026 meeting and February 25, 2026 discussion.

X. Vendor Invoice Lists (pages 15-18)*

Action is requested to accept the "Vendor Invoice Lists" and place them on file.

XI. Staff Reports (pages 19-66)

For information only is a report from Lynn Canfield. Other reports are deferred.

XII. New Business

a) Special Election (pages 67-70)*

CCDDB by-laws are included as background. With resignation of the Board President, a special election is needed. After hearing and closing nominations of officers to fill the unexpired terms, the Board may take an action such as "to elect [xx] as President and [xx] as Secretary of the CCDDB, effective immediately and ending when the required officer elections are held in July." Action is requested.*

b) Applications for Program Year 2027 Funding (page 71)

For information only is a list of requests for I/DD funding for Program Year 2027.

c) Program Year 2025 Service Activity Data (pages 73-96)

For information only, a briefing memorandum presents full year claims data, with analysis of utilization per program and by selected individual cases. Attached for reference is a report on Utilization and Outcome results of all I/DD programs.

XIII. Old Business

a) Emerging Threats

The Board may discuss threats to the safety and stability of people with I/DD and other vulnerable residents.

b) Input from People with I/DD (pages 97-98)

For information is input from advocates regarding DDB Resolution #1 and proposed pledge of actions. People with I/DD may choose to offer input to the Board and public at this time.

c) Engage Illinois

An oral update will be provided.

d) Evaluation Capacity Building Project Update

An oral update will be provided.
See https://www.familyresiliency.illinois.edu/resources/microlearning-videos.

e) disAbility Resource Expo and AIR Updates

Oral updates will be provided. See also https://disabilityresourceexpo.org and https://champaigncountyair.com

XIV. Successes and Other Agency Information

The Chair reserves the authority to limit individual agency representative participation to 5 minutes and/or total time to 20 minutes. See below for details.**

XV. County Board Input

XVI. Champaign County Mental Health Board Input

XVII. Board Announcements and Input

XVIII. Other Business – Closed Session*

The Board may move to "enter into Closed Session for Semi-Annual Closed Session Minutes Review Pursuant to 5 ILCS 120/2(c)(21). The following individuals will join this closed session: members of the Champaign County Developmental Disabilities Board, Executive Director Canfield, and Associate Director Bowdry."

If the motion is approved, those authorized will meet in the Putman Room and move for roll call and discussion. When discussion ends, they will return to the Shields-Carter Room, and the Board will call for a motion to return to Open Session, with a new roll call.

Once the Open Session is re-established, recommended action is to "accept the February 19, 2020, February 26, 2020, July 21, 2021, February 23, 2022, September 18, 2024, February 19, 2025, and October 22, 2025 closed session minutes as presented (or revised) and to destroy the recordings and to [continue maintaining them as closed] – OR – [open them]."

XIX. Adjournment

* Board action is requested.

**Public input may be given virtually or in person. If the time of the meeting is not convenient, you may communicate with the Board by emailing stephanie@ccmhb.org or kim@ccmhb.org any comments for us to read aloud during the meeting.

The Chair reserves the right to limit individual time to five minutes and total time to twenty minutes. All feedback is welcome. The Board does not respond directly but may use input to inform future actions. Agency representatives and others providing input which might impact Board actions should be aware of the Illinois Lobbyist Registration Act, 25 ILCS 170/1, and take appropriate steps to be in compliance with the Act.

For accessible documents or assistance with any portion of this packet, please contact us (kim@ccmhb.org).

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY (CCDDB) MEETING

Minutes January 28, 2026

This meeting was held at the Scott Bennett Administrative Center
102 E. Main St., Urbana, IL 61802
and with remote access via Zoom.

9:00 a.m.

MEMBERS PRESENT:

Kim Fisher, Dianne Husby-Gordon, Susan Fowler, Neil Sharma

MEMBERS EXCUSED:

Anne Robin

STAFF PRESENT:

Kim Bowdry, Leon Bryson, Lynn Canfield, Stephanie Howard-Gallo, Shandra Summerville, Chris Wilson

OTHERS PRESENT:

Danielle Matthews, Kelli Martin, AJ Zwettler, Heather Levingston, Sarah Perry, Laura Bennett, Jami Olsen, DSC; Hannah Sheets, Becca Obuchowski, Community Choices; Paula Vanier, Mel Liong, Eric Enger, Michelle Ingram, PACE; Jacinda Dariotis, Family Resiliency Center UIUC; Angela Yost, Jessica Heckenmueller, Lisa Benson, CCRPC; Brenda Eakins, GROW in Illinois; Annie Bruno, ARC of Illinois; Jenny Lokshin, Champaign County Board; Lezlie McCoy, Terri Bristow, PSCI

CALL TO ORDER:

Dr. Fowler called the meeting to order at 9:08 a.m. CCDDB member Dr. Kim Fisher requested to attend remotely due to employment obligations. In compliance with the CCDDB By-Laws a motion was requested by Dr. Fowler to allow her remote attendance.

MOTION: Dr. Sharma moved to allow remote attendance for Dr. Kim Fisher for this meeting due to employment obligations, as allowed in the CCDDB By-Laws. Ms. Gordon seconded the motion. All CCDDB members voted aye and the motion passed.

ROLL CALL:

Roll call was taken, and a quorum was present.

APPROVAL OF AGENDA:

An agenda was approved.

CCDDB and CCMHB SCHEDULES/TIMELINES:

Draft CCDDB and CCMHB meeting schedules and CCDDB allocation timeline were included in the packet and are posted online and linked in the agenda.

MOTION: Dr Fisher moved to accept the CCDDB schedule as submitted. Dr. Sharma seconded. A voice vote was taken and the motion passed.

ACRONYMS and GLOSSARY:

A list of commonly used acronyms was posted publicly and linked in the agenda.

CITIZEN INPUT/PUBLIC PARTICIPATION:

None.

CHAIR'S COMMENTS:

Dr. Fowler thanked staff for the pie charts for the Comparison of PY2025 Agency Revenues.

EXECUTIVE DIRECTOR'S COMMENTS:

Director Canfield reviewed the status of agency audits.

APPROVAL OF MINUTES:

Minutes from the 11/19/25 meeting were included in the packet.

MOTION: Dr. Sharma moved to approve the 11/19/25 board meeting minutes. Ms. Gordon seconded the motion. A voice vote was taken and the motion passed.

VENDOR INVOICE LISTS:

Vendor Invoice Lists were included in the Board packet. An addendum was included.

MOTION: Dr. Sharma moved to approve the Vendor Invoice List as presented. Ms. Gordon seconded the motion. A voice vote was taken and the motion passed unanimously.

STAFF REPORTS:

Staff reports were included in the packet for review.

NEW BUSINESS:

Special Election:
Deferred to the next scheduled meeting.

Agency Special Request:
A request from PACE, Inc., that the Board waive suspension of payments due to late PY25 audit and authorize CCDDB staff to release payments as scheduled, was included in the Board packet.

> **MOTION: Dr. Fisher moved to waive suspension of payments due to late PY25 audit and authorize CCDDB staff to release payments for January, February, and March. Dr. Sharma seconded the motion. A roll call vote was taken and the motion passed.**

Expo Activities for 2026:
A Decision Memorandum presented an update. Director Canfield reviewed the challenges of having an Expo this year because of various issues including the recent resignation of the Expo coordinators.

> **MOTION: Dr. Sharma moved to direct CCDDB-CCMHB staff to form an Advisory Committee to plan and carry out Disability Resource Expo activities, which may include an in-person event and to authorize the Executive Director to pay for related services and products using approved budgeted funds. Dr. Fisher seconded the motion. A roll call vote was taken and the motion passed unanimously.**

AIR Activities for 2026:
A Decision Memorandum presented an update. Ebertfest organizers have a final 2-day festival planned for April 2026.

> **MOTION: Dr. Fowler moved to approve up to $6,322.50 to share the cost of anti-stigma film sponsorship in Roger Ebert's Film Festival 2026 and to authorize the Executive Director and staff to issue payment. Dr. Sharma seconded the motion. A roll call vote was taken and the motion passed unanimously.**

OLD BUSINESS:

Resolution #1 Update:
An adaptation of the Resolution adopted by the CCDDB was included in the Board packet, with DRAFT actions for a multi-governmental pledge.

MOTION: Dr. Fisher moved to accept the 2026 pledge to residents with disabilities as presented. Dr. Sharma seconded the motion. A voice vote was taken and the motion passed.

Agency Special Request Update:
A Briefing Memorandum with an update on financial reporting by CU Autism Network was included in the Board packet. Although CUAN was working toward completing a financial review, their CPA firm has recently sent a letter of disengagement which was included in the Board packet. Ms. Canfield provided a brief recap, Board members discussed the 2024 contracts.

MOTION: Dr. Fisher moved to request an agency representative join Steven Beckett at the February meeting for a 15 minute time limit to discuss their request and answer Board questions. Dr. Sharma seconded the motion. A voice vote was taken and the motion passed.

Emerging Threats:
For information were articles published by Disability Scoop, regarding new requirements of Medicaid and plans to reorganize the US Dept of Ed.

Input from People with I/DD:
None.

Engage Illinois:
An oral update was provided.

Evaluation Capacity Building Project Update:
An oral update was provided by Jacinda Dariotis from UIUC. See resources developed by the team at https://www.familyresiliency.illinois.edu/resources/microlearning-videos.

disAbility Resource Expo Update:
See New Business (above.) See also https://disabilityresourceexpo.org

Comparison of PY2025 Agency Revenues:
For information was a report showing sources of all revenue on which agencies also funded by the CCDDB and Champaign County Mental Health Board (CCMHB) rely.

SUCCESSES AND AGENCY INFORMATION:

Successes and agency information were provided by Becca Obuchowski from Community Choices; Angela Yost from RPC; AJ Zwettler from DSC; Annie Bruno from Arc of Illinois; and Paula Vanier from PACE.

COUNTY BOARD INPUT:

Ms. Lokshin commented on the importance of financial accountability and that the County is facing a difficult budget planning season.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB) INPUT:

The CCMHB met last week with similar agenda items.

BOARD ANNOUNCEMENTS AND INPUT:

None.

ADJOURNMENT:

The meeting adjourned at 10:40 a.m.

Respectfully Submitted by:
Stephanie Howard-Gallo
CCMHB/CCDDB Compliance and Operations Coordinator

**Minutes are in draft form and subject to approval by the CCDDB.*

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY (CCDDB) MEETING

Minutes February 25, 2026

This meeting was held at the Scott Bennett Administrative Center
102 E. Main St., Urbana, IL 61802
and with remote access via Zoom.

9:00 a.m.

MEMBERS PRESENT:

Dianne Husby-Gordon (remote), Anne Robin, Neil Sharma

MEMBERS EXCUSED:

Susan Fowler, Kim Fisher

STAFF PRESENT:

Kim Bowdry, Leon Bryson, Lynn Canfield, Stephanie Howard-Gallo, Shandra Summerville, Chris Wilson

OTHERS PRESENT:

Danielle Matthews, Kelli Martin, AJ Zwettler, Heather Levingston, Sarah Perry, Laura Bennett, Jami Olsen, Patty Walters, DSC; Hannah Sheets, Becca Obuchowski, Community Choices; Paula Vanier, Mel Liong, Eric Enger, Michelle Ingram, PACE; Jacinda Dariotis, Family Resiliency Center UIUC; Angela Yost, Jessica Heckenmueller, Lisa Benson, CCRPC; Brenda Eakins, GROW in Illinois; Annie Bruno, ARC of Illinois; Jenny Lokshin, Champaign County Board; Ryan LaCosse, Best Buddies

CALL TO ORDER:

Dr. Robin called the meeting to order at 9:00 a.m.

ROLL CALL:

Roll call was taken, and a quorum was not present in the meeting room to allow Ms. Husby-Gordon to attend remotely.

APPROVAL OF AGENDA:

An agenda was reviewed but not approved.

CCDDB and CCMHB SCHEDULES/TIMELINES:

Draft CCDDB and CCMHB meeting schedules and CCDDB allocation timeline were posted online and linked in the agenda.

ACRONYMS and GLOSSARY:

A list of commonly used acronyms was posted publicly and linked in the agenda.

CITIZEN INPUT/PUBLIC PARTICIPATION:

None.

CHAIR'S COMMENTS:

None.

EXECUTIVE DIRECTOR'S COMMENTS:

Director Canfield reviewed the agenda, and many items will be deferred due to the lack of a quorum.

APPROVAL OF MINUTES:

Deferred.

VENDOR INVOICE LISTS:

Deferred.

STAFF REPORTS:

Staff reports were included in the packet for review.

NEW BUSINESS:

Special Election:
Deferred.

Review of Applications for PY2027 Funding (pages 21-26):
For information only, the packet included a briefing memorandum on the process for reviewing funding requests, with a checklist for (optional) use by Board members. A list of applications was also attached.

OLD BUSINESS:

Agency Special Request:
A Decision Memorandum offered an update on CU Autism Network as background for their request for extension of financial review deadline. Action was deferred.

Emerging Threats:
Deferred.

Input from People with I/DD:
None.

Engage Illinois:
None.

Evaluation Capacity Building Project Update:
An oral update was provided by Jacinda Dariotis from UIUC. See resources developed by the team at https://www.familyresiliency.illinois.edu/resources/microlearning-videos.

disAbility Resource Expo and AIR Updates:
See also https://disabilityresourceexpo.org

PY2026 Second Quarter I/DD Program Activity Reports:
For information, service activity reports from funded I/DD programs were included.

PY2026 Second Quarter I/DD Claims Reports:
Summaries of service claims from many I/DD programs were included in the packet.

SUCCESSES AND AGENCY INFORMATION:

Success and agency information was provided by Becca Obuchowski from Community Choices; Angela Yost from RPC; AJ Zwettler from DSC; Paula Vanier from PACE; Kelli Martin from DSC; and Jessica Heckenmueller from RPC

COUNTY BOARD INPUT:

None.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB) INPUT:

The CCMHB met last week with similar agenda items.

BOARD ANNOUNCEMENTS AND INPUT:

None.

ADJOURNMENT:

The meeting adjourned at 9:30 a.m.

Respectfully Submitted by:
Stephanie Howard-Gallo
CCMHB/CCDDB Compliance and Operations Coordinator

**Minutes are in draft form and subject to approval by the CCDDB.*

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VENDOR INVOICE LIST

Champaign County, IL FUND = Developmental Disabilities Board MONTH = January 2026

Vendor Number	*Vendor Name*	*Invoice*	*Invoice Date*	*Check Run*	*Invoice Net*	*Invoice Description*
1	CHAMPAIGN COUNTY TREASURER	Jan'26 DD26-078	1/1/2026	010926A	$ 35,420.00	DD26-078 Decision Support PCP
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-084	1/1/2026	010926A	$ 21,916.00	DD26-084 Clinical Services
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-091	1/1/2026	010926A	$ 43,583.00	DD26-091 Community Employment
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-081	1/1/2026	010926A	$ 52,333.00	DD26-081 Community Living
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-092	1/1/2026	010926A	$ 10,166.00	DD26-092 Connections
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-085	1/1/2026	010926A	$ 8,541.00	DD26-085 Employment First
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-080	1/1/2026	010926A	$ 26,666.00	DD26-080 Individual and Family
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-083	1/1/2026	010926A	$ 41,666.00	DD26-083 Service Coordination
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD25-086	1/1/2026	010926A	$ 20,333.00	DD25-086 Workforce Development

VENDOR INVOICE LIST

Champaign County, IL FUND = IDD Special Initiatives MONTH = January 2026

Vendor Number	*Vendor Name*	*Invoice*	*Invoice Date*	*Check Run*	*Invoice Net*	*Invoice Description*
1	CHAMPAIGN COUNTY TREASURER	Jan'26 IDDSI25-089	1/1/2026	010926A	$19,336	IDDSI25-089 Community Life Short Term Assistance

VENDOR INVOICE LIST

Champaign County, IL FUND = DDB MONTH = Feb 2026

Vendor Number	*Vendor Name*	*Invoice*	*Invoice Date*	*Check Run*	*Invoice Net*	*Invoice Description*
1	CHAMPAIGN COUNTY TREASURER	Feb'26 DD26-078	2/1/2026	020626A	35,420.00	DD26-078 Decision Support PCP
10146	COMMUNITY CHOICES, INC	Jan'26 DD26-095	1/1/2026	020626A	21,333.00	DD26-095 Customized Employment
10146	COMMUNITY CHOICES, INC	Jan'26 DD26-090	1/1/2026	020626A	19,416.00	DD26-090 Inclusive Community Support
10146	COMMUNITY CHOICES, INC	Jan'26 DD26-076	1/1/2026	020626A	4,000.00	DD26-076 Staff Recruitment & Retention
10146	COMMUNITY CHOICES, INC	Jan'26 DD26-075	1/1/2026	020626A	19,000.00	DD26-075 Self-Determination Support
10146	COMMUNITY CHOICES, INC	Jan'26 DD26-077	1/1/2026	020626A	20,250.00	DD26-077 Transportation Support
10146	COMMUNITY CHOICES, INC	Feb'26 DD26-095	2/1/2026	020626A	21,333.00	DD26-095 Customized Employment
10146	COMMUNITY CHOICES, INC	Feb'26 DD26-090	2/1/2026	020626A	19,416.00	DD26-090 Inclusive Community Support
10146	COMMUNITY CHOICES, INC	Feb'26 DD26-076	2/1/2026	020626A	4,000.00	DD26-076 Staff Recruitment & Retention
10146	COMMUNITY CHOICES, INC	Feb'26 DD26-075	2/1/2026	020626A	19,000.00	DD26-075 Self-Determination Support
10146	COMMUNITY CHOICES, INC	Feb'26 DD26-077	2/1/2026	020626A	20,250.00	DD26-077 Transportation Support
10170	DEVELOPMENTAL SERVICES CENTEI	Jan'26 DD26-082	1/1/2026	020626A	82,500.00	DD26-082 Community First
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-084	2/1/2026	020626A	21,916.00	DD26-084 Clinical Services
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-091	2/1/2026	020626A	43,583.00	DD26-091 Community Employment
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-082	2/1/2026	020626A	82,500.00	DD26-082 Community First
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-081	2/1/2026	020626A	52,333.00	DD26-081 Community Living
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-092	2/1/2026	020626A	10,166.00	DD26-092 Connections
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-085	2/1/2026	020626A	8,541.00	DD26-085 Employment First
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-080	2/1/2026	020626A	26,666.00	DD26-080 Individual and Family Support
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD26-083	2/1/2026	020626A	41,666.00	DD26-083 Service Coordination
10170	DEVELOPMENTAL SERVICES CENTEI	Feb'26 DD25-086	2/1/2026	020626A	20,333.00	DD25-086 Workforce Development
10424	PERSONS ASSUMING CONTROL OF '	Jan'26 DD26-079	1/1/2026	020626A	3,831.00	DD26-079 Consumer Control in Personal Support
10424	PERSONS ASSUMING CONTROL OF '	Feb'26 DD26-079	2/1/2026	020626A	3,831.00	DD26-079 Consumer Control in Personal Support

VENDOR INVOICE LIST

Champaign County, IL FUND = IDDSI MONTH = Feb 2026

Vendor Number	*Vendor Name*	*Invoice*	*Invoice Date*	*Check Run*	*Invoice Net*	*Invoice Description*
1	CHAMPAIGN COUNTY TREASURER	Feb'26 IDDSI25-089	2/1/2026	020626A	19,336.00	IDDSI25-089 Community Life Short Term Assistance

Legislative and Policy Conference Notes

NACo and NACBHDD 2026 Conferences and Board Meetings

Date: March 6, 2026
To:
Champaign County Executive Steve Summers and
Members of the Champaign County Board, Champaign County Mental Health Board (CCMHB), Champaign County Developmental Disabilities Board (CCDDB), and Association of Community Mental Health Authorities of Illinois (ACMHAI)
From:
Lynn Canfield, Executive Director of CCDDB and CCMHB, Legislative Committee Co-Chair of ACMHAI, Health Policy Steering Committee and Board of Directors of NACo, and Vice Chair of NACBHDD

Background

I attended Legislative and Policy Conference sessions and Board of Directors meetings of both the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) from February 21 through 27. The following notes are from sessions which may be of interest.

NACO Health Policy Steering Committee Meeting

Committee Chair Bruno Sabatier, Supervisor, Lake County, California, called the meeting to order, introduced committee and subcommittee leadership and NACo staff, welcomed new committee members, and reviewed the agenda.

Federal Partner Spotlight: Health Resources and Services Administration

Thomas Engels, Administrator, Health Resources and Services Administration (HRSA):

- HRSA holds a collection of very diverse programs. Organ Donation Integrity, e.g., in which Sec Kennedy is the first ever to decertify an organ donation provider and is leading the effort to stop fraudulent physicians taking advantage of patients.
- To recruit and retain providers (esp. primary and maternal care), HRSA's Bureau of Health Workforce partners with counties, academic institutions, and providers to improve access to high quality care. 22,000 clinicians were trained last year. National Health Service Corps student loan repayments for dentists, physicians, and more. The Nurse Corps Loan Repayment program had a two-year work commitment. Encourage applicants, as this has had a significant impact already in expanding health and behavioral health care.

- HRSA also funds behavioral health programs, including in rural areas where there are very few healthcare facilities to start with. In 2025, over $59m into workforce trainer training. Demand will rise through 2038, but the predicted shortages are staggering. HRSA designates Health Professional Shortage Areas.
- Training sites through academic programs which do reach rural areas. Incorporates training specific to those areas. Works with rural officials to consider needs.
- For integration of behavioral health into primary care and other safety net settings, in 2024 there were 1400 Federally Qualifying Health Centers (FQHCs) in the US, which operate 16,200 sites, serving 32.4m people (a million person increase from 2023). This includes school-based centers. Increased use of mobile dental units also reaching schools. More training for dental workforce. FQHCs also do screenings, medication assisted treatment, and individual treatment planning. Each Board of Directors must include 51% from the community or patients who use the FQHC location. They also work with Ryan White HIV Program, treating HIV as a chronic disease, with high participation. FQHCs exceeded national average with hypertension, diabetes, obesity; they know how to get patients in and keep them. 17.4% mental health visits in 2024, of which 74% were repeat visits.
- To restore access to maternity care in areas where it has disappeared, RMOMS program, loan repayment, and outreach. HRSA supports 870 maternal health providers. Application cycle is open, with 15% to go to rural areas. MATCARE has an $8m program focused on this. Title 5 goes to states who work with counties to build infrastructure. Maternal and Infant Home Visiting Program reaches new or expecting parents in 1,260 counties, to improve parenting skills (e.g., nutrition counseling); many served through this program choose to become home visitors themselves. Healthy Start Initiatives in 115 underserved communities (23 are rural.) https://hrsa.gov has a Healthy Start Locator tool.
- National Maternal Hotline 1-833-TLC-MAMA has reached 89,000 people, with info about depression and stress and connection to healthcare professionals.
- Screening of mental health and substance use - reached 3.5m children last year.
- Rural Communities Opioid Response (RCOR) program connects people to services post inpatient treatment, helps create support teams.

Assessing Congressional ACA Cost-Containment Proposals: Affordability and Coverage Implications

Congress is considering proposals to reduce costs within the Affordable Care Act (ACA) with potential effects on premiums, out of pocket costs, and affordability for individuals.

Hon. Wendy Askew, Monterey County, California:

- Proposed changes will have profound impacts on county budgets and services. How to lower costs while maintaining responsible access to care? How are policies likely to perform in practice?

Anna Bonelli, Director of Health Policy, Committee for a Responsible Federal Budget:

- Proposals last fall did not contain cost-reduction. Debate was on who's going to pay, the federal govt through subsidies or individuals? Health care costs are very high and growing, crowding out opportunities to do other things. Cost-sharing reductions (CSRs) - assistance for low-income folks' out of pocket costs - were discontinued in 2017; costs shifted to silver plans, raising federal government's cost.
- ACA cost-containment proposals: bringing CSRs back; consumer-driven changes (more control over the $ through Health Savings Accounts, e.g.) which might lower costs for everyone - hasn't been tried anywhere, so it's not clear that would work; utilizing price transparency has not proved helpful.
- Values leading the conversation: no unified set of values at congressional debate level. ACA and Medicaid expansion were good at reducing numbers of uninsured. The great unwinding of Medicaid (Biden) focused on how to retain coverage. No longer the emphasis; the administration wants to reduce costs; recent proposal relies on catastrophic plans (higher costs to individuals); although this expresses the value of consumer choice, actuarial shows long-term poor health outcomes and higher costs later. If you stratify the risk pool (different from ACA pool), the high individual costs are for the sickest. Countiess may share what they find important.
- Proposals to generate meaningful savings without increasing the risk pool or individual costs? Ban facility fees in private plans- site neutral payment policy in Medicaid. Reference policies where government employee coverage is limited as Medicare payments are (designed to meet costs). Price cap. Competition. Better ways to encourage the supply of care among providers. See https://www.crfb.org/.

Navigating Medicaid Changes Under HR 1: Strengthening State-County Partnerships for Program Integrity

Strong collaboration between state and county governments will be critical to ensuring program integrity, effective administration, and continuity of services for residents.

Lauren Kallins, Senior Legislative Director, National Conference of State Legislatures:

- Focus on health and human services issues. NCSL is largest bipartisan org, with over 7000 elected members, representing states' interests at a federal level. Under HR1, what states are required to do, some fixed requirements and some flexible: finance at least 40% of Medicaid costs (in 2018,12% came from local); implement work requirements (no way around this); conduct eligibility every 6 months (not annually); comply with limits on provider taxes; no non-citizens.
- Provider taxes very significant; with no new taxes or increases, states and counties will pick up the costs. Local can include intergovernmental transfers and certified public expenditures. State direct payments will be reduced to new upper payment limit beginning in 2028.
- Rural Health Transformation Program provides $50b to states over 5 years. Impact on counties is that Medicaid covers 24% of rural residents.

- Demand for services impacted: 80 hrs/mo community engagement for expansion adults aged 19-64, without kids or a disability, and incomes up to 138% of federal poverty level. People who don't meet work requirements may end up in county-owned hospitals and safety net providers. Noncitizen eligibility is another huge loss.
- Administrative impact on states and counties; go-live date of December 1, 2026.
- Fixed financing limits and mandatory admin increases.
- Flexibility in that eligibility can be determined at state or county level. States may provide funds, backfilling county costs with state general funds. Implementation design also flexible (how to do work requirement outreach, verification workflow process, alignment with TANF and SNAP.)
- Multi-stakeholder effort: engage legislators early, educate them about county resources and projected impacts, track and share the implementation impacts.

Hanna Maniates, Director of Medicaid Programming, National Association of Medicaid Directors:

- Represent 56 Medicaid directors (states and other US jurisdictions.)
- Changes in Eligibility, Fiscal, and Program Integrity. Medicaid directors want to implement the statute and use taxpayer dollars efficiently.
- In Sept, outreach to members re work/community engagement requirements. In Oct, changes to FMAP eligibility for non-citizens. In Jan 2027, implementation of work requirements and 6-month redetermination and retroactive coverage changes. In Oct 2029, fiscal penalties.
- States can choose longer lookback periods. If a state cannot verify compliance, loss of match. A final CMS rule will be implemented by June; states' implementation date is Jan 1, 2027. Optional exemptions, etc.
- State Medicaid agencies are focused on effective implementation, getting clarity from CMS, etc. How will they define the exemptions and qualifying activities? IT systems changes need to start by March, prior to the guidance. Very concerned about the payment error rates. Significant changes to eligibility and enrollment systems, including adding portals for uploading documentation, building out connections to other data sources to verify exemptions (payroll, e.g.) and compliance. Increased use of data sources may increase costs.
- States need to include implementation costs in their FY27 budgets. They also need to project changes to the enrolled population. Not a lot of data on how these changes might affect acuity.
- Eligibility workforce capacity critical. Some data (jail, e.g.) originates from counties. Communication will be complex but important. www.medicaiddirectors.org

Scott Centorino, Visiting Fellow & Former Special Assistant to the President for Domestic Policy, Foundation for Government Accountability:

- Welfare Integrity and Accountability. Why all these changes? Reason #1 - money. Medicaid was on an unsustainable trajectory, the biggest line item in every single state. Something needed to be done to save these programs. Reason #2 - want the programs to work for those who need them the most. Over time it has expanded to

include many able-bodied adults, but it still needs to work for the truly vulnerable. Both of the big measures were designed to protect the integrity of the original program. Reason #3 - more welfare means less work. Big economic development problem is the lack of workers. 150% increase in food stamp enrollment. 130% increase in Medicaid enrollment. 62% increased enrollment in labor force participation. Reason #4 - social capital, knowing your neighbors and community members. Work is the way to get to know the neighbors. Way more valuable than government, which won't be there for you when you need them at 4AM.

- Fraud by Design. States need to reduce fraud or face financial penalties if they cannot bring payment error rates down. Ex parte renewals = auto renewal magic, in which forms are prepopulated with old data. Broad Based CE is when food stamp recipients are fast passed - TANF recipients are auto-enrolled in food stamps, then onto Medicaid. Presumptive Eligibility - welfare on a hunch, while waiting for determination. Reasonable Opportunity Periods – 90-day free trial for citizenship, that never ends. Self-Attestation - run on the honor system rather than verified.
- Food stamp error rates of Illinois, Florida, California, Georgia and others are over 10%. 80% of errors are eligibility errors. Three ways to fix your welfare programs: enforce the work requirement; verify eligibility up front; ask tough questions. To avoid penalties, codify basic program integrity for Medicaid and food stamps.

Nick Duran, Executive Director, Medicaid Business Development, Aetna:

- Served as a Florida state legislator, worked in public health system.
- Focus on the community engagement (work/volunteer) requirements and residency data. CMS reinforced that states should use multi-modal verification of residency. Insurers can help with that, with the most up to date contact information. States can't use Managed Care plans to determine beneficiary compliance with community engagement requirements.
- Establish a standard pathway for verified contacts to move quickly into eligibility. If residency data lags, the system will encourage unnecessary disenrollment.
- Need one script, not several, as a formal message to educate enrollees. Managed Care plans can help with education and reminders but not with compliance.
- Requires much coordination across governance, to understand and route. Time to go back to the states because we'll need: written clarity of the state's role and expectations; data sharing agreements and minimum data sets; standard outreach protocol; and a plan of support that complies with what we know are the rules and community engagement. Prepare your top important issues, as the states wait on CMS rules, as this all has to move really fast.

2026 Congressional Health Care Preview

Marielle Kress, Senior Health Advisor, Senate Finance Committee Minority, and
Anna Rose Moore, Senior Health Policy Advisor, Majority, Senate Committee on Finance:

- Behavioral health continues as a priority.

- Two items with (off-record) bipartisan approval; collect all the data; workforce can't handle the data collection and reporting demands (e.g., Chair Sabatier's county has a 39% vacancy rate), but AI cannot cover this work.

Emerging Federal Opportunities for Advancing the Crisis Services Continuum

Greg Puckett, West Virginia, introduced the panel and topic.

Chris Santarsiero, Vice President Government Affairs, Connections Health Solutions:

- SAMHSA produced much guidance on crisis continuum. The "crisis receiving" model was founded by psychiatrists and is the foundation of Arizona's current system. Everyone wants the "no wrong" door model, but it's not so easy. Model is now in VA, PA, NM, AZ, for the most acutely ill. Medicaid is the backbone. To run a 24 hour psych facility requires capital investment, but that doesn't guarantee solutions to the problem. Systems should look at the services you provide; most communities have one system for the civilly committed and one system for community access. County government leads the redesign of behavioral health crisis response. There are state plan amendment avenues, waivers, CCBHCs, other existing tools. 45 states are maximizing Medicaid best practices. Tremendous room for growth.

Andrea Bailey, Supervisor, Prince William County, Virginia:

- Introduced herself by family relationships to those with support needs!! Serving the second largest population in VA. Public behavioral health, DD, and SUD services. Problems facing the region include high rate of placement for Temporary Detention Orders, long ER waits, extended waits for behavioral health crisis, and overreliance on law enforcement. Limited immediate care options. High recidivism rates. Through work with unhoused people, it became clear that lack of mental health care played a role, needed to be a focus. No Wrong Door for BH crisis and offering medical detox within the facility, trauma treatment, receives adults and youth (16 beds, 16 recliners for each population.) Wanted to do wraparound services, so there's a pharmacy, SUD treatment, and homeless outreach. County bought the vacant 79,000 sf building, retrofitted for accommodations. Asked the governor to put this in his budget, which he did, as $460m for behavioral health. Later Youngkin named the Prince WIlliam project in his budget and added $40m. Bridging the gap from ER care to supports and services and reducing law enforcement's role.
- The Crisis Now Model, collaborative approach, connecting to resources at each point in the crisis. 8.8m young adults reported an MH crisis, 42% have untreated MI. Someone to Call, Someone to Respond, Somewhere to Go. Description of services co-located at the center. Partner with state and federal officials to meet local needs.

Robin Cheung, Policy Advisor, Congressman Dan Goldman, Democrat – New York:

- Worked in an ER! Medicaid funding is essential to the crisis continuum of services. 16 beds per IMD rule, which was set at the beginning of Medicaid, so we keep trying for IMD reform. Demonstration/pilot programs are fine, but the law needs to be updated, whether inpatient psych or short term crisis stabilization. Michelle Go Act would raise the cap to 36 beds, a bipartisan bill to build capacity for both types of care. Other legislation to improve crisis care across the country. Congress is at an all time low for bills passed.

NACo Health Policy Committee Business Meeting

Policy resolutions and platform changes submitted within the 30-day deadline… Those passed are valid through the Annual Conference. 13 resolutions plus 3 cross-claimed with other committees. No emergency resolutions.

In Support of Relief for Counties in the Administration of HR 1 Medicaid and SNAP Provisions:

HR1 involves substantial cost shifts from federal to states and to counties. Partner to address this (with Dept of Health and Human Services, Dept of Agriculture, and Congress), align reporting, exempt vulnerable populations from work requirements and eligibility redeterminations, allow cross-program reporting for administrative reviews, and assist counties with the additional costs. Counties will likely be carrying a higher share of safety net costs. Friendly amendment was approved unanimously. *Amended resolution was approved by 38 ayes, 2 abstentions.*

Addressing Gun Violence and Emerging Firearm Threats Affecting Counties:

Local governments pick up the slack financially and see the impacts of trauma. Share resources across state lines. The current related resolution doesn't include ghost guns or information sharing. This resolution respects lawful gun ownership but acknowledges that guns can be 3d printed at the library. Strengthens federal action against trafficking while honoring local authority. Medicaid reimbursement for trauma related services, since counties will carry the cost of impact on uninsured people. The current platform addresses gun violence under Justice and Safety, but this would modernize the platform. *Resolution passed (two abstentions.)*

Request Congress and the Administration to Fund Research on CTE and Its Impact on Students' Mental Health:

Tackle football led to fifteen times more Chronic Traumatic Encephalopathy cases. Long term consequences, financial and suicide death. Focus on early teens through young adulthood. *Resolution passed unanimously.*

Support the Healthcare Workforce:

Significant shortages across this workforce. Changes in Visa and related issues threaten to further reduce the workforce. Exempt healthcare workers, increase the student loan cap. Friendly amendment was further amended (to include more types of healthcare professional) and passed. *Amended resolution passed unanimously.*

Support the 340B Program:

Supporting safety net hospitals. 340B discount pricing, regardless of dispensing location. Penalties when not upheld. Friendly amendment is further amended to simply say all county health services. This passed. *Amended resolution passed unanimously.*

Reduce the Frequency of Reevaluations for Home and Community Based Services (HCBS):

For I/DD or other permanent disability, require re-evaluation only every three years (rather than annual) or when there is a substantial change in function. Friendly amendment approved. *Amended resolution passed unanimously.*

On the Expansion of Federal Healthcare Programs for First Responders:

Allow for expansion of healthcare so we can purchase healthcare to cover our local first responders. Supports universal healthcare and saves money by adding to the pool. Voluntary program. Discussion on including firefighters, law enforcement, and Emergency Medical Services, including dispatchers. Friendly amendment to add this detail. *Amended resolution passed unanimously.*

Urge the DEA to Classify Kratom Alkaloids as Scheduled Controlled Substances:

Counties are frontline to the Substance Use Disorder (SUD) crisis. Kratom is rising, with long term effects better understood. Seven states have banned it. Maternal use of Kratom can cause infant death. Need the DEA to do education on it. Friendly amendment passed. Discussion of the risk of focusing on substances separately rather than on the disease of substance dependence; affirmation that the lack of info plus wide availability (even to children) and addictive nature. *Amended resolution passed unanimously.*

Preserve Medicaid Eligibility for People with Disabilities:

Allow states flexibility to verify medical eligibility internally. *Passed unanimously.*

In Support of Ensuring Parents' Rights in Health Decisions including Vaccine Requirements:

To rebuild confidence in healthcare and vaccination, in county led public health efforts. Increase willingness to bring children to doctor visit. Keep families engaged. Western State Health Alliance and Northeast Public Health Coalition have emerged, and other states suing - unify states' efforts. Opposition to this resolution was based on concerns about moving backward in public health practice (as measles re-emerges, e.g.), that we need science-based approaches to vaccines). This proposal could erode public trust and public health, which we should be protecting during infectious disease season. Prior resolution to disseminate only fact-based information covers part of this, while this resolution may reverse progress. While there is a need for trust building, the details here are problematic (so go back to last year's resolution, in which it was addressed). This raised a point of order, but Blaire Bryant said this is not a correction of current platform. Another opposition: immunization rates have dropped far below what would achieve herd immunity, and many parents are not bringing children in for well visits. Support for this proposal from a provider who said it would build trust. Supreme Court is now looking at facts rather than narratives and overturning problematic decisions. Discrepancies between risks listed in vaccine package inserts and providers. *8 votes to support, 33 opposing, 3 abstentions. FAILED.*

Advancing Mental Health Equity and Access for Underserved Youth:

Cross claimed by Education Committee. Establish a framework for advancing culturally competent care to address the growing mental health crisis, especially among youth, the most dramatically impacted. Access to care is deeply unequal. References a trauma-informed prevention model, "Shop Talk," in Cook County. *Resolution passed unanimously.*

Urge Congress and Department of Health and Human Services to Rescind or Amend the Medicaid Home and Community Based Services Setting Rule to Remove Barriers to Appropriate Community-Based Housing and Services:

Sponsor is the mother of two autistic adults. Settings rule has restricted the development and operation of appropriate care settings. *Resolution passed (one abstention).*

Secure Increased Reimbursement for Rural Emergency Medical Services (EMS):

Increased EMS necessary to provide the services. *Passed unanimously.*

Healthy Counties Innovation Council Meeting

NACo EDGE Presentations

Brett Beckerson, Director of Policy and Strategy, National Council for Mental Wellbeing:

- Many equate "behavioral health" with "criminogenic risk" so we shift the focus to well-being. Champion CCBHCs and Mental Health First Aid (MHFA), especially at work, having seen the pressures on public and health employees during the pandemic. Various MHFA modules. Summary of CCBHC essential services.

Chris Blanchett, National Program Director, Public Promise Insurance, NACO EDGE:

- Products include Pharmacy Benefit Manager coalition, student loan debt program.

Welcome and Overview

Janet Thompson, Healthy Counties Innovation Council Chair and Boone County, Missouri Commissioner:

- Focus has been on access to health and related resources for our residents. Today, legislative advocacy to improve that access. Strengthening how we communicate challenges and our ideas for solutions.

How to Advocate to Your Policy Makers to Improve Access to Health

Nalini Padmanabhan, Communications Director, deBeaumont Foundation:

- A public health focused foundation, advancing public health outcomes and supporting PH staff. Toolkit on effective communication released December 2025. More educational messaging didn't translate well to policy making audience.
- Five focus groups (in purple states) helped lead to findings on three key perceptions that fuel distrust: PH involves difficult tradeoffs that may not be worthwhile; PH professionals are driven by ideology rather than practicality; PH ignores the role of individuals in shaping their own help.
- Developed a message to overcome these perceptions: show aspirational impact: Public Health as a force that strengthens local well-being and economy. Emphasize local and listening, by showing that recommendations come from listening to communities; community and individual are complementary.
- Choose examples wisely, matching the audience's views and needs: conversation starters should align with current understanding, e.g., water supply testing, pattern analysis; highlight role of individual choice (e.g., prenatal care, vaccination); collaborate for deeper impact (highlight cross-sector work, e.g., with law enforcement, mental health crisis training).
- Message Do's: plain language, visual and tangible, highlight Public Health track record, use stats to highlight return on investment.
- Message Don'ts: avoid policy jargon, don't make the solution feel overwhelming, avoid data from divisive sources, avoid over-indexing on equity, position public health and healthcare as complementary, avoid overexplaining public health.

- https://debeaumont.org/resources/communicating-about-public-health-policymakers/

Nicole Rongo, Vice President, Government Relations & Strategic Partnerships, CGI Digital:

- County Showcase Video Program is a cost-free video initiative designed to elevate Healthy Counties efforts and drive measurable community impact. Video is tangible and relatable. Build awareness, trust, and momentum.
- Counties choose the topic, usually healthy living or healthcare. Community storytelling with a purpose. CGI revenue is from private sector participation, so these services are FREE to counties. Help make your healthy living assets feel real.

Carol Moehrle, District Director, Idaho North Central Public Health District:

- Idaho regional system of boards of health.
- Meet in person if possible, prep with local PH officer, take the health officer with you or accompany them, keep meetings to one hour, give policymakers a chance to share, have one page of information for a take-home (one story statewide if a statewide initiative - consistent messaging). Example on Vape Prevention. They want to know about people in their jurisdiction so they can also tell these stories.
- Focus on priorities they may hear about in session and then on what you want them to know about their constituents and PH. Share community and individual stories; know their personal stories that connect with PH - cancer, home visiting, WIC, opioids, epi, tobacco.
- Weave in return on investment. Focus on money in a follow-up meeting. If requesting funding, be prepared to suggest where to find the funds. Go further than sharing the data: hook them in first.
- Follow up always. Thank them, build trust. One meeting a year is not enough. Reach out monthly/quarterly, with any new information and short messages.

Discussion:

- Some confusing messages from HHS, so keep messaging around whole community health and science-based, understand the triggers.
- Advance locally collected data and share it out to larger areas, some of this continues, add storytelling data, use infographics to back up stories or data.
- Best practices for communicating about controversial approaches like harm reduction are to know the audience and tailor to the audience, capture stories and data which might convince them (ROI, data on what works, etc.)

Midsize County Caucus Meeting

Phyllis Randall introduced Senator Warner who works in the national security and economic development spaces, understands how federal policies impact communities.

Senator Mark Warner, Virginia:

- acknowledged counties as foundational support and frontline for safety net and emergency planning, the first call and the last line of defense. Counties employ over 3m people and work across all levels of government. Housing is the biggest challenge, having been ignored for years. Teachers, firefighters, and nurses have been priced out of living in the communities they serve.
- Bipartisan activity: the Senate has 20 different proposals under The Road to Housing Act; the House has a mirror package with additional tools. To get these across the finish line, partnership with counties due to local decision power.
- Examples: a community using data center revenue to invest in housing; a church property working on veteran housing. No single approach will solve it.
- Federal funding may help projects of local relevance.
- Average age of 41 to afford a home purchase now.

Connor Torossian, Federal Transit Administration, US Dept of Transportation:

- Review grants for busses, ferries, etc. Framework of Secretary Duffie's priorities.
- Phase 2 of bus grant program is starting, just allocated $3bn, lots of money available for our communities to apply for. Have $9.4m for tribal transit grants, to announce in the next month or two. Economic development greatly benefits from transit.
- Planning grant program is starting in the next few months. Bus safety and accessibility program ($10m). Ferry program to be announced. Safety is top priority.
- Accessibility too ("All Stations Accessibility Program" 15m to update existing facilities.) Innovation, whether through AI or autonomy, research.
- Surface Transportation Reauthorization expires Sept 30. Had been funded at unprecedented level, congress is debating this now.
- World Cup in GA 2026 - FTA has $100m to help host cities. Capital Investment Grant program is large.

Shannon Smith, Director, Public Sector, CAI, on Data Centers, Cybersecurity, and AI:

- How does AI impact cybersecurity?
  Active threats such as credentials abuse, exploitation of legacy systems, cost and time of updating systems, recognizing scams, ransomware. Generative AI allows threat actors to move faster, refining attacks at a very low cost. Large language models are also pulling information from websites, from which nuggets of threat emerge. It is not bound by countries or organizations, so the trading of code makes counties even more vulnerable.
- How do we address the use of AI in cybersecurity attacks?
  Strong credential hygiene, with updates and multifactor authentication. Increase AI education. Regional collaboration. Responsible AI must include security as a key tenet. State and federal regulations are changing quickly. Similar to the sudden widespread use of mobile phone. Build a secure AI practice: think about this when using tools beyond those approved by IT. Machine learning is not new.
- Are people using approved AI systems within your county?

Prioritize those services which use AI best. Start this conversation with your residents. Role-specific considerations - people fear being replaced, but systems could be more efficient.

- Data center use is accelerated by AI (hyperscale data centers). Now using 4% of electricity and will rise to 11%. Use of water.
  The pros: increased tax revenue, to reduce the burden on residents or to increase services; visibility, center for economic development; more efficient use of industrial zoning (e.g., 1980s malls converted); increased capacity for all of these.
  The cons: exhaustion of resources; historical use of land; because they're super-automated, they may not increase employment after construction; risk to quality of life (noise, traffic, visual).
- What to do to address datacenter build out?
  Moratoriums (6-12 months), public reviews for constituent opinion, use agreement.
  OR be an early adopter, create those incentives, and negotiate aggressively.
  Do it mindfully, to make sense for your county.

Phyllis Randall:

- Lock down your land use. They don't take as much water as they used to, but they do use a lot of electricity. Don't do a moratorium because your state won't uphold it.
- Louden County has more data centers than any and can speak to the good and bad. Another speaker noted that coming legislation could interrupt your plans. State associations should help.

Ronald Kurtz, Assistant Secretary for Community Planning and Development, US Dept of HUD, on Housing Affordability and Support:

- Regulatory reform, minimum energy standards to be rolled back, but local regulations continue to be the biggest cost burden hindrance to housing development. Change construction and other regulations. Opportunity zone initiative is permanently codified in HR1.
- Collaborate with states to rezone areas to increase development.
- Flagstone programs such as Community Development Block Grants (CDBG), with $5.3bn to allocate by April 3. Expediting review of applications to develop sustainable, effective housing. Section 108 loan program can be used to leverage CDBG for gap financing.

Continuum of Care Landscape: Examining Shifts in Homelessness Response

Angela Conley, Commissioner, Hennepin County, Minnesota, "Minnesota Strong":

- Still getting people housed and doing street outreach. Heading Home Hennepin is their Continuum of Care. County staff support the point in time count and data for annual HUD application.

- $91m of ARPA funds went toward relieving homelessness, through street outreach, supportive housing, affordable housing, supports, housing-focused case mgt, low-barrier shelter. eviction prevention, and more. The result was a 33% decrease in unsheltered homelessness, compared with 12% increase nationally.
- “Shelter All” policy for families. Expand capacity for families with children.
- Ended veterans homelessness, (now accredited by three federal agencies), by working with many partners and addressing it one veteran at a time, rehousing each one within 90 days, using proven strategies.

Ryan Mello, County Executive, Pierce County, Washington:

- Efforts similar to those of Hennepin County. $4-5m annually for CoC activities, with county as the collaborative applicant. Most funds went to permanent supportive housing (308 units, 1600 people) and rapid rehousing (1900 people).
- To protect this funding from immediate federal threats, King County led multi-county legal challenge against the coercive proposed terms, got a preliminary injunction and now work through appellate courts. Updating partners on federal issues.
- Set aside $25m of local funds to backfill gaps in federal responsibility. Advocated for state legislative amendment to allow more flexible use of local revenue, which has been dedicated to new or rehabbed housing. Convened leaders in business, philanthropy, health care, and others to create a Resiliency Hub to guide the community response to federal admin chaos. Plan and design collective strategies.

Kaitlyn Krutso, Rep Rosa DeLauro, Connecticut:

- CoC is state level. Governor created an emergency fund to fill the gap. Representative DeLauro had a press conference; an unhoused resident passed away. $466m increase for CoC plus guardrails so that HUD will release a new NOFO. A bipartisan issue. If no acceptable NOFO in time, any grants which expire March 31 will be extended one year. Same if not by July 1. 60% minimum of this NOFO must be for permanent supportive housing and rapid rehousing.
- SAMHSA's $2bn termination was announced and reversed within 24 hours. If these are cut, loss of wraparound services for people in these situations. Medicaid cuts may also be devastating. Downstream costs and pressure on law enforcement, uncompensated care in emergency rooms.
- How do you leverage funding you have? Take legislators on site visits to service provider settings to show what will be lost.

Tracy Haden Loh, Brookings Institution:

- Worked on disruptions of American downtowns during COVID. Since then, lots of interviews about buildings and CoC, as this issue evolves very rapidly.
- Long term homelessness trends, though the country as a whole has made progress. It has gotten a lot worse in certain places, but those stick in policymakers' minds, a big information gap. Even within big cities, there is enormous variation. Therefore,

it's difficult to have sweeping, inflexible federal policies. PIT count data is poor, with a big gulf between what we count and what counts.

- Major swings during pandemic disrupted policy too: in 2021, when ARPA flexible resources went out, there were huge improvements, even in spite of people not wanting to live in close proximity and in spite of rents rising. Afterward, the migrant crisis came. Gulf between perception and reality about the period of 2020-2022; hybrid work contributed to the impression that homelessness went up instead of down, as a very small unhoused population moved to places where they were much more visible, creating this impression. Policy makers misunderstood this and chose NOT to do 2021 policy again, thinking it hadn't worked.
- Huge influx of migrants created pressure on certain cities, but they were managing this new crisis without any federal aid. The spark of immigration policy touches the oil barrel of homelessness. We can find ways to address homelessness when we are really motivated.
- The challenge of balancing resources between managing perceptions and reality; people link homelessness to criminality very strongly, even swaying elections, with a focus on individual behaviors such as sleeping outside or public drunkenness. The discourse is now framed around individual behaviors, leading to policies which make the systemic problems worse. Safe camping or other non-congregate shelter of last resort is a productive way forward.
- Counties can solve this: look to FUSE; use social impact bonds; respond to fiscal incentives to build PSH; scale of regional housing market; neighborhoods and cities should be involved, to tailor to needs hyperlocally and be culturally appropriate; brokers and building owners know the neighborhoods and can help if engaged; share data and resources to move the region and achieve economies of scale.

NACo Board of Directors Forum

JD Clark, NACo President, called the meeting to order.

Policy Resolutions for the NACO Board as the Resolutions Committee

Eryn Hurley, Chief Government Affairs Officer:

- 41 proposed resolutions, considered by the 10 policy committees. Major focus on maintaining local control, enhancing federal funding, delaying implementation of some HR1, transparency around payment in lieu of taxes. 38 were approved, 3 tabled. One was passed by Health but tabled by Justice, and since Health was the lead sponsor, it will be brought tomorrow.

Local Government Legal Center

Amanda Karras, Executive Director and General Counsel, International Municipal Lawyers Association:

- Major Supreme Court cases shaping policies, all of which will be decided by June:

Pung versus Isabella County, a property tax case. When you foreclose on a property, what is owed to the previous homeowner? Do you owe the fair market value minus the tax debt or the sale value? Calls into question the whole process - excessive fine? Who determines FMV?
Birthright Citizenship Executive Order Case. Does it violate the 14th amendment? Significant impact on vital records, social services, administrative staff. Without federal public benefits, uncompensated care, etc. What is a public charge? Earlier Trump versus Casa decision, that a judicial district cannot issue a nationwide injunction. This got more complicated when a group of states got involved. Other remedies in the lower courts sort of look like nationwide injunctions. It used to be that smaller cities could wait for larger cities to sue over a public act and then use that, but this is no longer the case. Federal agencies are putting conditions on grants now, as directed (e.g., DOT, HUD.) Some conditions challenged by multi-state suits are gone but could come up in other agencies' grants.
Others: Second amendment cases may impact how you analyze firearms law; Section 2 of Voting Rights Act will have impacts; preemption by federal laws.

- Rapidly changing landscape. Risks of acting too quickly or slowly. Best to stay close to associations to keep up. Risk management depends. If you wait too long, grant opportunities may close. If you go too fast, you might spend $ on court case and then your state does too.
- DEI conditions had the potential for a false claims liability, so no one would sign. Needed a definition of 'illegal DEI' since the federal administration definition might differ from case law.

Federal Policy Landscape: Trends, Insights, and Priorities

Matthew Chase, NACO CEO & Executive Director:

- Policy resolutions lead to specific pieces of legislation.
- Partnership with state associations.
- Strategic patience! (e.g., CDC, SAMHSA cuts announced and then restored.)
- State Departments of Transportation own 16% of roads but get majority of funding. NACo has created transportation profiles for every county, to understand local infrastructure needs (county owned roads and bridges). These can be viewed at https://ce.naco.org/?dset=Surface%20Transportation&ind=County%20Surface%20Transportation%20Profiles
- County Explorer also shows FEMA details, disaster declarations, and more, at https://ce.naco.org/?dset=Disaster%20Declarations&ind=Disaster%20Profiles
- General sessions will feature committee leadership and champions of specific bills.

Eryn Hurley:

- Emphasis on national standards preempting local authority. Counties need to be represented during the legislative process.
- Major restructuring of federal funding. Dederal agencies are reviewing programs for alignment with administrative priorities; county compliance with executive orders.

- Related to Surface Transportation Reauthorization (expiring Sept) are challenges with the bipartisan law, esp with funding not making it to local level. State DOTs not reallocating, and block grant funding is very limited in scope. NACo drafted the BASICS Act with county needs in mind, introduced it two weeks ago to bipartisan sponsors. A marker bill, to be inserted into the other package, ensures more access to federal aid highway and bridge dollars, provides more support to rural and small communities through regional commissions, and expands project eligibility. Letters of support from League of Cities and others. Ask House Reps to support this. Stories that will help are the significant inflationary impact and weight of traffic.

Blaire Bryant, Senior Legislative Director (Health):

- Institutions of Mental Disease (IMD) exclusion, from the onset of Social Security Act, was meant to prevent institutionalization. To improve continuum of crisis behavioral health services, revision would increase the cap from 16 to 36 beds. The current cap limits capacity. Modernize the policy as we know more about crisis care and need more tools. A promising bill is the Michelle Alissa Go Act in the House. A unique county issue since properties are also involved. Also important to Sheriffs.
- Also prioritizing Medicaid Inmate Exclusion Policy reform. Due Process Bill would allow use of Medicaid pre-trial and Reentry Act prior to discharge. Some states currently use 1115 demonstration waivers for this reentry exception.

Brett Mattson, Senior Legislative Director (Justice and Public Safety):

- Congressional staff met with NACO last year and used feedback to develop the FEMA Act HR4669. Issues were delays in reimbursement, paperwork reduction, etc. Solutions outlined. Public assistance under FEMA to change to a grant program. After a disaster, FEMA would have 90 days to review a community's plan. A single disaster application portal, to apply for funding from all four granting agencies. BRIC program (pre-disaster mitigation) to return as a formula grant rather than competitive. Also includes a transparency piece, a public assistance dashboard so you can check progress on each of your claims. Hoping for a Senate companion bill, still working on a bipartisan bill.
- President's FEMA Review Council, with Secretaries Noem and Hegseth. No recommendations yet, potentially mid-March.
- 900 counties a year have a natural disaster qualifying for federal assistance.

Jared Grigas, Associate Legislative Director:

- Housing Reform key provisions: two bills promising the biggest reform since Fair Housing Act. Supporting these will signal willingness to partner. Key formula programs, reauthorization for Road to Housing, expanding workforce housing, expanding authorized block grant usage. A landmine inside the Senate bill is tied to housing growth rate, setting penalties below the median and bonuses above it. NACO data on the impacts of this are not as severe as expected due to exemptions.
- To increase affordable housing, need more housing stock and more flexibility.

Jeff Thorsby, Legislative Director:

- SAVE Act and MEGA Act regarding elections. Massive scope. NACO's platform does not take a position on identity verification, though concerned about administrative burden to implement it. Criminal penalties for election administrators; questions about who is liable. Practical questions regarding name change and how county staff will manage documents. Every state handles these differently, so how will it be organized? Make sure legislators understand what this really entails.
- Rather than defining ourselves by parties, think about impacts on counties' work.

We are Counties: Preview

Lori Dicker, Chief Public Affairs Officer:

- Storytelling plus public affairs advocacy campaign. The launch is tomorrow, with microsite and "sizzle" video. Sets the tone that counties deliver and counties matter. Built for sharing with decision makers. Includes a toolkit for counties on the web hub. Paper materials. Short documentary style video series, aligned to federal priorities. Podcast series and other 'explainers' to elevate county stories, co-brandable content with infographics and tools, and campaign swag. For info, see the webpage www.NACO.org/WeAreCounties
- Three policy summits tomorrow, with media coverage to build media relationships.

NACO EDGE Solutions: Achieving New Savings and Value for Counties

Bill Jasien, Executive Chairman, NACO EDGE:

- The three solutions are no longer in Beta: pharmacy benefit management; procurement platform; high performing investments. Procurement Advisory Council, Retirement Readiness Council, Public Promise Advisory Board. Check testimonials on www.NACoEDGE.org and talk to each other about results.

County Practices and Innovations: New Resources and Cohorts

Ashleigh Holand, Chief Program Officer:

- Office hours. Directory of Programs and Services. Tools for counties on the website https://www.naco.org/page/directory-programs-resources. Initiatives and Cohorts by topic. Click through for current active programs within each and to look at past programs and their evergreen content. New option to receive emails on initiatives.
- Forecasting opportunities page, on what is open right now. Applications to join Public Health Leadership Initiative and the Rural Energy Academy, with plain language explainers that can apply to all counties.
- Peer Exchanges including recent one on rural energy and several tours with videos for those who could not attend the in person event. Lots of interest in this topic.
- Rural Energy Academy Calendar, inaugural Technical Assistance cohort. In June, a peer exchange on Energy and Economic Development.
- Early Childhood restarting. Opioid Crisis too. Streamlining Benefits. New programming on Juvenile Justice. Proposals to various foundations to support priorities, including serious mental illness.

Central Region Meeting

Pledge, roll call by state, acknowledgement of veterans, past NACo officers, and staff. States represented were Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, and Wisconsin.

Brett Mattson, Justice and Safety Policy, NACo, Update on Legislation:

- BASICS Act, sponsored by Pennsylvania's Bresnahan and Michigan's McDonald Focus on surface transportation, realigns some funding from state to local authority.
- FEMA Act HR4669, bipartisan bill, worked with NACo's disaster task force, to reform FEMA, converting from reimbursement to grant and 90-day review, adds a universal disaster application (to go to all four federal agencies). Cleared out of committee by 57 to 3. Need a Senate companion piece. Butting up against the FEMA review council's recommendations, which were due December 2025.
- Michelle Alissa Go Act, to reform the IMD exclusion raising the cap from 16 to 36. Bipartisan letter of support is circulating.
- Congressman Westerman, Chair of the House Natural Resources Committee, will be speaking on the SPEED Act HR4776, to reform the permitting process for NEPA and identify counties as a partner in the review process and streamlining environmental protection rules.
- Road to Housing (Senate)/Housing for 21st Century (House). These bills do not align at all. NACo is supportive of many provisions.

Kat Patterson, Senior Program Manager for Children, Youth, and Families, NACo:

- Transforming Human Services Initiative, in response to the major shift of responsibilities from federal to county. Kellogg Foundation is interested in providing food to families. Special invitation to Minnesota, Ohio, Wisconsin, and the other states which administer SNAP.
- Virtual calls, learning discussions, in person peer exchanges, resource hub including generative AI.
- Focus on storytelling, to help counties meet the moment. New tech has the potential to improve and streamline our work, looking to learn from peers.

John Matelski, Chief Information Officer, NACo, jmatelski@naco.org:

- Counties are at risk regardless of size due to the high value data all have. Still have systems in legacy mode. Ransomware and other exploits and attacks increase.
- AI could improve efficiency and service delivery (targeted use cases to enhance operations). Current landscape includes pilot projects and strategic shift, beyond experimentation toward the implementation of sustainable, operational AI tools.
- Urgency for AI Adoption: growing interest and investment; demand for scalable solutions, as people want that "Amazon" experience; tangible benefits, with transformative potential through streamlining operations, unlocking deeper insights from data, and improving service quality and efficiency for constituents.

- Governance and Ethical Frameworks: defining clear policies and procedures for AI use; ensuring ethical considerations are at the forefront; and building public trust through transparency and accountability.
- Workforce Readiness and Training: assess skillsets and training needs; develop upskilling and reskilling strategies; and foster AI literacy and adoption culture.
- Guardrails and Risk Management: data privacy and security; algorithmic bias mitigation; and performance metrics and evaluation.
- Moving Forward: A Roadmap for Success, expanding successes in one project.
- Join the Tech Xchange - https://www.naco.org/page/county-tech-xchange. There is a paid membership for extra materials later, but as many county staff and officials as are interested may join.

Miranda Morvey, Senior Operations Manager, NACo:

- Apply for NACo Achievement Awards!! Winners will be announced in June. Changes in the process. Take time to recognize individuals and the great work they've done.

NACo Board of Directors Meeting

J.D. Clark, President of NACo, called the meeting to order.
Debbie Wise, Circuit Clerk of Randolph County, Arkansas, delivered the invocation.
Rodney Dial, Mayor of Ketchikan Gateway Borough, Alaska, led the Pledge of Allegiance.
NACo staff tracked roll call at the entrance.

White House Intergovernmental Affairs Update

Jared Borg, Deputy Director, State Governments and Special Assistant to the President, White House Office of Intergovernmental Affairs:

- The Office is liaison from the administration to state and local governments.
- The Board of Directors will be invited to the White House to meet cabinet officials and other leadership. Administration will set up councils to 'cut through the red tape' on project large and small, e.g., counties should not have to wait longer than states for permits, and they have cut down significantly so far.
- Regional assignments for day to day contact.
- Final FEMA review council meeting is next week, with recommendations to come.

Update on NACo's Intergovernmental Disaster Reform Task Force

Co-Chair Adrian Garcia, Commissioner, Harris County, Texas:

- Introduction of FEMA Act is the result of sustained county advocacy.
- Reform should emphasize clarity, local flexibility, local land use and rebuilding, reduction of long-term costs, partnership across governments.
- New NACo toolkit supports this work.

- Task force will respond to council recommendations, with final report at 2026 Annual Conference, on the roadmap for federal disaster response reform.

Hon. Allan Dodson, Judge, Faulkner County, Arkansas:

- Task force brought real world examples to federal officials, around timelines and lack of coordination. Met with council members to share that any reforms should streamline rather than complicate the process for local governments.
- With council recommendations, task force will analyze implications for counties.
- Acknowledgement of NACO staff.

Approval of Minutes from the Meeting on December 5, 2025*

Nominations to the Board of Directors*

- Adam Bradford, Supervising Planner, Passaic County, New Jersey, nominated by National Association of County Planners (NACP).
- Andrew Eads, County Judge, Denton County, Texas, nominated by Texas Association of Counties.
- Emily Haxby, Supervisor, Gage County, Nebraska, nominated by Nebraska Association of Counties.
- Schuyler Harding, Director of Communications & External Affairs, Advancing Georgia's Counties, nominated by National Association of County Information Officers (NACIO).
- Honorable Mark Ozais.
- Erin Skaar, Commissioner, Tillamook County, Oregon, nominated by Association of Oregon Counties.

Audit Committee Report*

David Nicholson, Chair, Alisha Bell, Officer Liaison, & Luis Guardia, Chief Financial Officer:

- Reviewed 2025 travel expenses. No material findings.
- On Saturday, reconvened for an update on the 2025 audit; interim audit completed in November; a combined audit; field work will begin in April; final report will be presented in May at the Western Interstate Region Caucus.

Finance Standing Committee Report*

George Dunlap, Chair, and Luis Guardia:

- Assets increased 4.9m, and net assets 4.7m. Careful cash management.
- Positive bottom line driven by realized and unrealized (reserved) income. $1m operating surplus.
- Annual rebalancing of net assets; approved an increase in reserves for potential investment fluctuations.

Presidential Appointments: Credentials and Nominating Committees

President Clark:

- Several committee chair appointments.
- Notification of National Affinity Group Name Change, now the National Association of Queer County Officials.

Membership Standing Committee Report

Renee Couch, Chair:

- 210 more renewals than at this time last year.
- 7 new counties joined in 2026 (includes Ford County, Illinois).
- 1,816 county officials representing 866 counties. Many new attendees at this conference.
- Director of Member Engagement Tammy Tincher has accomplished so much.

Programs and Services Standing Committee Report

Tarryl Clark, Chair:

- Recommendations to explore additional programming for modernizing technology, identifying budgeting strategies and cost allocation, establishing partnerships across enforcement agencies at all levels of government, guidance on ADA compliance, guidance on AI tools.
- Prefer active group work rather than larger, passive sessions.

IT Standing Committee Report

Gregg Weiss, Chair, and Jon Matelski, NACo's Chief Information Officer:

- 127 elected officials and IT leaders meet regularly to support navigating this rapidly evolving landscape.
- Strengthen cybersecurity, risk awareness and threat response, compliance with ADA standards, accelerating adoption of secure .gov domains.
- Land use and county budget impacts related to data centers and other technology procurement issues.

CEO Progress Report

Matthew Chase, CEO:

- County Pulse survey received many thoughtful answers to a long (45 minute) survey.
- Acknowledge the toll that serving on executive committee has taken on the officers, especially in their elections back home.
- Many retirements are coming up, with institutional knowledge leaving. Please prepare new leaders for engagement on committees and other.
- State trends in property tax: even though this is not a federal issue, it's a major trend, with input from state associations and others. Seeing lots of land use preemption at the state level and lots of property tax cap issues. Will share the follow up in May. In

the research, you'll see that we're not advocating for higher taxation but rather for local choice regarding self-taxation. The trend is to cut the ability for locals to tax themselves and rather to go to the state legislature for re-approvals. NACo will help with messaging, data points (e.g., US citizens pay $1.3tr in individual federal income tax, they pay way more in sales tax and income tax than they do property tax) to put property taxation into context and to compare with the value you get in return.
- Practical realities of running elections, security, cybersecurity, technology upgrades.
- FEMA work has been active on many levels and with many partners.
- The Big Shift. County hospitals, jails, and behavioral health programs all face huge impacts of Medicaid and SNAP requirements. But when you take these threats together with preemption efforts, it's more like the Big Squeeze.
- Advocacy. What are the issues for which we need peers across the country in order to share strategies? Worked with large foundations on childcare.

NACo Board of Directors Convenes as the Interim Resolutions Committee

President Clark called the meeting to order and explained the process. Each committee's report was approved, and one proposed resolution was pulled for discussion.

Policy Committee Reports

Agriculture and Rural Affairs:
- Supporting Water Reliability for Ag and Food Security
- Securing Increased Reimbursement for Rural EMS
- Urging the US Dept of Ag to Prioritize Farmer and Rancher Mental Health and Include Counties as Key Partners in Program Development and Implementation

Community, Workforce, and Economic Development:
- Regarding HUD Funding
- Encouraging State Housing Authorities to Promote Consistent Section 8 Administrative Plan Provisions Supporting Housing for Individuals with I/DD
- Urging Congress and US Dept of HUD to Modernize Section 504 Regulations to Permit Disability-Specific Housing Options Chosen by Individuals with I/DD
- Urging Congress to Promote Workforce Participation of Neurodivergent Individuals through Targeted Federal Incentives and Skills-Based Employment Policies
- Strengthening and Sustaining the Manufacturing Workforce in the US

Environment, Energy, and Land Use:
- Supporting Revisions to the Clean Water Act Such that Local Gov't Transportation Projects are Subject to a Maximum Replacement Ratio of 1:1 for Wetland Impacts
- Supporting Reauthorization of Great Lakes Restoration Initiative

- Support of Maintaining or Increasing Funding levels for the Clean Water and Drinking Water State Revolving Funds
- Clarify and Modernize NEPA to Allow Targeted Modification of Ongoing Environmental Reviews for Infrastructure Project

Finance, Pensions, and Intergovernmental Affairs:

- Urging Congress to Approve the John R. Lewis Voting Rights Advancement Act of 2025 & Ensure Full Federal Funding for County Election Administration Compliance
- Including Active and Retired Reserve Component Status on the US Decennial Census and the American Community Survey Questionnaires
- Only one of those was approved in committee – not clear which

Health:

- Relief for Counties in the Administration of HR 1 Medicaid and SNAP Provisions
- Addressing Gun Violence and Emerging Firearm Threats Affecting Counties
- Requesting Congress and the Administration to Fund Research on CTE and its Impact on Students' Mental Health
- Support the Healthcare Workforce
- Support the 340B Program
- Reduce the Frequency of Reevaluations for HCBS
- Expansion of Federal Healthcare Programs for First Responders
- Urging the DEA to Classify Kratom Alkaloids as Scheduled Controlled Substances
- Preserve Medicaid Eligibility for People with Disabilities
- Ensuring Parent's Rights in Health Decisions including Vaccine Requirements (failed in committee)
- Advancing Mental Health Equity and Access for Underserved Youth
- Urging Congress and Dept of HHS to Rescind or Amend the Medicaid HCBS Setting Rule to Remove Barriers to Appropriate Community-Based Housing and Services
- The gun safety resolution is pulled for separate discussion:
  Chair Sabatier provided the overview, read the proposed policy. The author of the resolution was ready for any questions. A member shared that the one line may have been background information, on untraceable items which complicate prosecution - the author agreed to leave this in the background section (rather than policy.) Another member expressed concern that data collection should not include gun registration and that untraceable might include inherited guns - author agrees to adjust this, as it was specifically for ghost guns and converted machine guns; she acknowledges the limited law enforcement resources which are further burdened by untraceable weapons. Another member says this is a slippery slope, since many veterans make their own guns. Back to the data collection, not related to gun registration. Another member objects to three policy lines where the meaning might have been more specific - move to table this again for a single policy position, so that we can re-debate this in full, rather than re-write during this meeting.

Human Services and Education:

- Supporting the Major Richard Star Act
- Ensure Continuity in SNAP Benefits
- Expanding Veteran Benefit Eligibility
- Reducing Chronic Disease in Children 0-18 to reduce Requirement for Special Education and Special Services

Justice and Public Safety:
- Concerning FEMA Reimbursement Rates for Mutual Aid Response
- Protecting Emergency Responders

Public Lands:
- Concerning PILT Side B
- Encouraging the US Dept of Interior to Increase Transparency and Data Sharing for Payments in Lieu of Taxes (PILT) Calculations
- Reaffirming the Federal Land Policy and Management Act
- Moving the National Marine Fisheries Service out of the Department of Commerce to the Department of Interior
- Supporting the Delisting of the Mexican Wolf
- Requesting National Park Fees Support Park Management, Infrastructure, and Visitor Access

Telecommunications and Technology:
- Local Control for AI Policy Making
- Preserving the Pricing Transparency for Telecommunications Services
- Extending the Deadline for Web-Based ADA Compliance

Transportation:
- Support of the National Trails System Act
- Supporting Flexible Federal Transportation and Infrastructure Funding to Enhance Access, Safety, and Recreation on Federal Public Lands
- Urging Congress to Strengthen Federal Protections for Rail Corridors and Prioritize Rail Infrastructure Activation

Caucus Reports

Large Urban County Caucus, Adrian Garcia, Chair:
- Housing is our central focus. Sharing local data and coordinating our advocacy to shape federal policy.

Midsize County Caucus, Christian Leinbach, Chair:
- First meeting was very well attended; content on AI, cybersecurity, and housing.

Rural Action Caucus, Terry Wilbur, Chair:
- Research on rural leadership (what helps/hinders civic engagement.)

- Senate perspective on rural challenges and legislative agenda.
- Update from DOT leadership; new opportunities for infrastructure and access.

Western Interstate Region, John Peters, President:

- Endangered Species Act Reform. Need transparency and reforms which recognize local government.
- Revenue streams, PILT (land use), and schools. Advocacy efforts for reauthorization.
- Looking forward to over 90% attendance at May 5-8 meeting in Maui County, Hawaii.

Other Business

- Rural Action Caucus in September, with the energy conversation.
- Today's panels include the Surface Transportation Reauthorization Bill, AI/Data Centers/Land Use, and Disaster Response (a very bipartisan effort.)
- Request from a member that we change the by-laws to have back up representation in leadership; communication is important; people do leave mid-term.

Illinois State Association of Counties (ISACo) Meeting with Senators Duckworth and Durbin

Senator Durbin asked the group what was on our minds and responded to priorities and questions. Senator Duckworth joined briefly to add details.

Housing

- A bipartisan housing bill will be introduced this week. Areas of downstate have been desperate for jobs and yet in places like McLean, Rivian's 7,000 employees can't find housing. University communities have an immediate need for more student housing, though this is not expected to continue. Zoning issues predominate.
- Research on regressivity in property assessment reveals a tendency to over-assess lower value properties and underassess higher. If Federal Housing Finance Agency data, which belongs to the public, could be made public, this could inform adjustments in assessment practice and lower these inequities in property taxation.

Medicaid Reform

- $1 trillion reduction in Medicaid spending will hurt people, hospitals, and local economies. Premiums are already rising and coverage dropped. Uncompensated care falls to counties. Illinois will lose 9 hospitals and 93 nursing homes. Medicaid Expansion programs related to opioid use disorder treatment will be shut down.
- A group of twelve bipartisan members, all aware of the huge losses coming, had been meeting actively to develop solutions. Due to some insisting on a new provision (federal abortion ban), these conversations ended.

- Cook County Commission President, Toni Preckwinkle leads NACo's work on this issue, which is a gigantic cost shift. Local leaders should keep pushing their representatives, who do know already. Of those anticipating closure, one hospital in Illinois which serves four counties and is a major employer in the region, is already relying on some medical providers to volunteer their time.
- In Carbondale, the top Medicaid wish is for pediatric dentistry. Because of the low reimbursement rates, even fewer dentists accept Medicaid, so poor children with toothpain are waiting 4 months for an appointment and a full year for treatment.

Surface Transportation Reauthorization

- Senator Duckworth is on this committee and does not anticipate full reauthorization or reform, but more of a bandaid. The appetite for it is not there. Trust is lost, partly due to the Secretary's cutting of infrastructure program grants, of which Illinois had many already approved or started, due to administration priorities related to DEI and low marriage and low birth rates.
- She asked for notification of slowed or discontinued payments on existing projects.

SAVE Act

- The issue is what will constitute an acceptable form of ID. Passports are expensive. Birth certificates may have older names. Naturalization certificates are rare.
- Despite the fact that vote fraud is quite low, this has already passed the House. If it does not pass the Senate, the administration may well send law enforcement to monitor election activities.

Energy

- Kankakee and Will Counties in particular need better electrical transmission grid (substations and more), as do most. Adequate infrastructure is a four-state effort.
- California's solar developers are grabbing marginal acres where farmers had to drill very deep for water to flood these fields. Some hope through coordination of effort.

Other Concerns

- Senator Durbin remarked that Congress is very slow to deal with the most notorious issues and that while we are in a painful moment, we will be better off for it afterward. He noted many prior bipartisan efforts which had been successful, but that harmful rhetoric is now in the way.
- Cook County officials expressed concern over other threats to civil liberties. Mass deportation/detention is not solving the stated problem; the court-ordered report on detainees showed that only 5% had criminal records. No movement on accountability; wearing masks and having no identification or warrant inhibit effective law enforcement.
- Lake County asked whether to expect federal standards for data centers. Serious concerns with big initial impacts; disclosure and local/state standards matter.

- McHenry County officials asked why we don't have a better path to immigration and citizenship. Senator Durbin worked with a group twelve years ago, which had found strong support for an immigration policy reform bill, which was killed by the other party. An orderly process, prioritizing non-criminals, is needed, and critical sectors of the workforce (healthcare, food production, construction) rely on immigrants.

NACBHDD Spring 2026 Board Meeting

Chair David Weden opened the meeting, led introductions, and reviewed the agenda.

In Partnership w/ Netsmart, Jonah C. Cunningham, NACBHDD President and CEO, presented the 2026 Board with books.

Federal Policy Updates

Jonah Cunningham:

- Not productive with legislation or much else; difficulty with the main role of passing appropriations bills. 11 of 12 current fiscal year bills are done, not Dept of Homeland Security. Under FEMA (which is under DHS) are disaster distress line and crisis jointly administered by SAMHSA.
- For 2027, they will have to pass 12 appropriations bills. President's budget in April or May. Merging SAMHSA into AHA was in the last one. They usually want to pass things quickly during an election year so they can get back to campaigning.
- Rural Health Transformation. Restructuring FDA.
- 900 current SAMHSA staff, going to 500 - limited ability to respond to requests; grantees unable to spend-down all their grant dollars because they can't reach anyone for guidance, especially on new rules.
- Punitive actions by the administration, grants cancelled without detail.
- Leadership changes within departments. No Assistant Secretary for MH/SUD at SAMHSA. While they may be independent in writing, their IT and admin going over to HRSA, an unofficial merger.
- Looming challenges from HR1. Guidance in June from CMS, on the community requirements, financing changes, provider tax, and program integrity. Must utilize claw-back authority in 2028. There are other investigations into public programs.
- Input from people with disabilities has been helpful in responses.
- For rural health grants, the state defines the locations, at least one in a rural area.
- Will NACBHDD submit public comment on the Department of Education exclusions of professional degrees? Yes, we have signed on, might add our own comments. Each federal regulation defines "rural" differently. The way states define it has an impact; crisis centers tend to be in urban areas but serving rural ones. The money was meant to be a rural hospital gap filler, but now it will be spread thin across many rural counties for other important services.

- Secondary requirements to work requirements. Concern about legal barriers to sharing confidential data across sectors. The Legal Action Center is working on this. How prescriptive should CMS be in their guidance?

Chair Report

David Weden, Texas:

- David Coe, Ginny Palin, and I will serve as the nominating committee.
- Updating and renewing the strategic plan.

NACo Board Representative Report

Lynn Canfield, Illinois:

- Interim Policy Resolutions, several related to DD.
- AI and ADA compliance.

Intellectual and Developmental Disabilities (I/DD) Committee Report

Grace Pennix on behalf of Adam Hermann, Ohio:

- One meeting since our last board meeting, with good attendance. Hosting through glueup, and now held quarterly, with the next one April 14.
- Chair is Adam Hermann and team from Ohio Association of County Boards for DD.

Behavioral Health and Justice Committee Report

Annie Uetz, Iowa:

- Several meetings, a lot of focus on housing and the HUD NOFO. Medicaid suspension rather than termination upon incarceration. Updates from Jonah. Good attendance but room for more. Next is May 7.
- Discussion of states in which the 1115 waivers include this MIEP waiver. Jails still contract for medical, and justice partners might struggle with what's happening and what the state wants them to do for behavioral health. Utah in the process of implementing this too, but intake process is a disaster.

Directors of State Association Committee (DSAC) Report

Kyle Kessler, Kansas:

- IMD Exclusion, which will be a topic here, as well as tech and AI. More opportunities for modernization, whether through CCBHC or Rural Health Transformation.
- Enhanced Medicaid match for mobile crisis response, set to expire in 2027.

National Association of Rural Mental Health (NARMH) Report

Shauna Reitmeier, Minnesota:

- Thanks for continued support of NARMH. Fully executed contract now for support.
- Conference Sept 27-29 in Santa Fe. Call for proposals is open, and the link for submitting these is on the website. Room block is already open. NACBHDD members get the NARMH rate for NARMH registration.

- NACBHDD's in-person fall board meeting will be held there as well.

Rural Committee Report

Chip Johnston & Megan Rooney, Michigan:

- Meeting set for March 11, will partner with NARMH on issues. Megan stepping in and Chip back. Timely with the Rural Health Transformation grants coming up. Megan added that her plane was stuck in Chicago.

Approval of Winter Meeting Minutes*

Financial Report*

Jonah on behalf of Rene Hurtado, Texas:

- Financial Update: switched from Tiffany Faulkner to YPTC (Your Part Time Controller), for more board oversight and to prepare financials for audits or grant applications; transitioned from cash to accrual basis. There is a recognized loss, though we ended with over $36k, resulting from the transition and from increased accounting expenses. Some initial travel to recruit new members, an investment in the organization. In the future, we hope for reserves of $10k. Three revenue lines were lower than expected: membership fees (slow to pay and fewer than hoped, will be better in 2026); corporate partners down (retraction happening broadly, maybe some fear of retrenching, but we have a new one and hope with the newly approved Corporate Partner Program.) Mike D moved, Annie seconded; motion passed.
- Proposed 2026 Budget: two grant proposals with NACO. Review of expectations. Tim moved, Chip seconded; motion passed.

Membership Committee Update

Cherryl Ramirez, Oregon:

- Focus on recruitment and retention. Very staff driven committee, but members are expected to reach out to regional contacts. Still working on Las Cruces County, New Mexico, King County, Washington, and Cook County, Illinois.
- Retention efforts by encouraging more committee participation or otherwise making NACHBDD a resource for existing members.
- Grace explained that Glueup has profiles for each organization, with contacts for each; reaching out to make sure we have the right names.
- Meeting every other month, next on March 13, 10AM Pacific Time.
- David Weden: we will trim some of the board once the membership has grown.
- Committee is helping with public/private entity definition of who can be a member.

Membership Report

Grace Pennix, Operations Manager (formerly Membership Coordinator):

- 89 new member contacts; 28 email campaigns; 5 events/meetings, not including Jonah's presentations.

- This conference is sold out for the second year in a row. Marketing and outreach have been very positive. Recruited two students from George Washington University to help. Health Policy student will continue with us on a project (more detail later.)
- Glueup is easier to access due to being embedded in the website. 100% states can receive discount on their products, and there are some benefits for expansion states. The website is now the sole registration portal, and we have direct access. Uploading weekly update newsletters to that site.
- October 21 and 22 will be the second annual virtual Fall L&P Conference.
- Policy & Advocacy section, upload member events, ongoing refinements.
- Completed a prospective member document and creating one to send out to existing members to refresh them on benefits at renewal.

State System Report

Grace Pennix:

- Sample state systems were selected, as covering all 50 was too much.
- Sources of funding for each are included in these charts. Many have regional or state funding and regional or county authorities. Wisconsin is county-based.
- Discussion of what's happening with various DD waivers, per state. Helpful resource for those looking for the best solutions, so this could inform an advocacy piece.
- Carve-in versus Carve-out, and whether there's a single managed care. This is very relevant in California, where MH and DD are bifurcated, and a 1115 waiver for IMD SUD services is structured as an opt in, distinct from the MH services. A lot of the conversation is focused on health plans as separate from the safety net programs - why behavioral health markets are different and why this matters to policy makers; we don't have legal authority over the money, and these systems are dysfunctional.
- Add "Getting Rid of the Medicaid Middle Man" since they mostly just keep access and authorization down. Public sector based is not the aberration, but the private IS. Private managed care has average net profit of $2bn a year.

Facilitated Discussion of Year Ahead

- David Weden noted state changes in reaction to federal activities. Things happening federally mirror what Texas has been dealing with for some time.

NACBHDD Updates

- Jonah reviewed implementation of the strategic plan:
  Updated policy advocacy toolkit (pillar 1, goal 1.2);
  Increased Conference attendance (pillar 2, goal 2.2) - in person sold out twice;
  Virtual conference (pillar 2, goal 2.2) - save the date for Oct 21-22.
- Goals for 2026: no meetings without agendas, complete technology migration, establish partnership boundaries, improve communications and more; Grace is interested in a leadership role through systems ownership and in building professional development and external network; Jonah will maintain 12 strategic

relationship visits while reducing time drains by 30% and eliminate reactive scheduling, especially as he prefers not to meet with consultants on demand.
- Quarterly committees are I/DD, BH & Justice, and Rural.
- Directors of State Association Committee meets bimonthly.
- Quarterly professional development trainings with Chris Wimbush: scenario planning, crisis communications, leadership and self-management, building psychology safety. Each session will be 90 minutes.
- Summer Board Meeting will be on May 8 on Zoom.
- Upcoming: officer elections in fall/winter; foundation for new strategic plan (summer/fall); member recruitment and retainment (committee meetings.)
- Spring L&P Conference Overview: review of agenda.

NACBHDD Legislative and Policy Conference, Day 1

David Weden said "Planes, Trains, & Automobiles" shows how much we can overcome by working together. Jonah Cunningham hopes to offer great content, cuisine, and community.

Opening Keynote

Tison Thomas, Acting Director of Center for Mental Health Services, SAMHSA:

- From Michigan, with concurrent waivers for MI, SUD, and I/DD, and 47 mental health programs. At SAMHSA for 16 years, and Acting Director since Dr. Everette was lost to the Reduction in Force cuts.
- Consistently since 2000, the Center for MHS was involved with NACBHDD, as he learned when he looked back through the presentations of those prior directors.
- Make America Healthy Again (MAHA) focuses on making the programs more efficient, using gold standard science, delivering better outcomes (for childhood chronic disease, mental health, nutrition, environmental toxins). Outlined in the MAHA Commission Report and the Make Our Children Healthy Again strategy.
- 1 in 4 have a Mental Illness. Of those, 5 have a Severe Mental Illness (SMI). High suicide risks. High rates of anxiety or depression in younger people. 1 in 6 have a Substance Use Disorder. There are many treatment gaps, as co-occurring conditions tend to be treated one at a time.
- Reverse the trajectory of increased SMI, addiction, and loss of life; provide effective interventions urgently; and work better with people to respond to their needs.
- Strategic Priorities: preventing substance misuse, abuse, and addiction; addressing SMI; expanding crisis intervention care and services; improving access to evidence based treatment; long term recovery/sobriety; and identifying and addressing emerging behavioral threats. Core work areas include information and collaboration. Key outcomes for decreasing rates of MI, SUD, suicidal ideation, homelessness, infectious disease transmission, and more.
- New grant, pilot programs, and services initiatives related to HEP-C, opioid response, expanding Assisted Outpatient Treatment (AOT) and civil commitment,

ending harm reduction practices, real-time data. SAMSHA funding for 2026 for MH, SUD prevention and treatment, health surveillance is increased over 2025 levels.
- To view grant opportunities, see https://www.samhsa.gov/grants
- Working on the NOFO to address mental health needs among the unhoused. Efforts to support people are fragmented, locally and nationally. Talked to the HUD Secretary about prioritizing housing for individuals with MI. Particular concern about anosognosia and expanding AOT. Early Diversion program NOFO will be released soon. Working with DOJ on AOT, also in their NOFO.
- Considering how to integrate nutrition into the priority categories, working with National Institute of Mental Health for research, reviewing literature on the science.
- For 988 Lifeline Toolkit, https://www.samhsa.gov/mental-health/988/partner-toolkit

Health Policy Insiders: Navigating the Evolving Landscape

Alison Barkoff, Health Law and Policy Professor at GWU
Reyna Taylor, National Council for Mental Wellbeing
Andrew Kessler, Slingshot Solutions
Ashley Holmes, National Minority AIDS Council

- With 2025's new administration, congress, and HR1, what can we expect in 2026?
- Rapidly changing circumstances. 2026 will be dominated by planning for implementation, coming so soon. Community engagement requirements are on everyone's mind, since CMS guidance comes in June but states must be in compliance quickly after. Complex budget impacts on states and communities. Regulations coming without the public comment opportunities we're accustomed to, plus wildly changing rules. The world of public health is changing quickly, changing the partnerships and funding that got us through the pandemic, and now the language around vaccinations impacts high risk groups (e.g., autism). Fraud accusations targeted at HCBS in the last four days, and 6 month moratorium on Medicare Durable Medical Equipment supplier enrollment.
- Drastic change in process. HR1 is not final just because it passed. The Secretary has immense power to set rules on how it will be executed. Some may be exempted from work requirements, but don't get too excited about that because changes in provider tax will reduce available funds for approved services. The keyword now is fraud. Last night, they froze $259m of Medicaid allotments to Minnesota. Not expecting many changes from the last budget; expect cuts, merging of programs, not a friendly environment. The difference is that it all changes in an election year, with polls and special elections capturing attention and driving how Congress responds to issues. Focus on appropriations and regulatory work. Never seen anything like the current environment, in which you have to check the phone before making any comments, as they are obsolete within three weeks. Defensive posture: where we had been used to advocating for improvements and making demands, now trying to protect what we have. Defense wins championships.
- As states and counties implement HR1, how can we influence federal regulations and timelines? Push back with advocacy. Reconciliation 2.0 might not be coming as

people are concerned with constituents' votes, which helps us articulate our points. Need to keep a seat at the table, so we might not push as hard as before. With MI, SUD, and I/DD, position ourselves as non-partisan and focus on human impacts.

- Elections will play a huge role. Quiet cuts don't get as much attention (e.g., CDC grant cuts in some blue states.) Advocates are already stretched thin.
- Three kinds of legislators in DC are Democrats, Republicans, and Appropriators. Tom Cole, Chair of Appropriations Committee, is clear on what he won't talk about. He was concerned when the administration started directing funding, as this is Congress' job. SAMHSA had deep reductions in staff but not programs. If the money goes away, we can get it back, but if the programs go away, we cannot. Top priority is to keep SAMHSA's doors open, keep them existing on paper, and get to 2029.
- Stay engaged with Health Education Labor and Pensions Committee. The advocacy pushback against SAMHSA cuts met with the appropriators who had not been aware of those cuts; the package now includes language about 72 hour notice of increases (so they can brag) or cuts (so they can push back.) Providers can't manage cuts coming that fast. Appropriations for AHA were not taken up, instead increased program funds. Keep attention on statutory authority (to create doubt) for 2027.
- Avoid making them pick a favorite cause. Protect ACA, access, prevention, and care, which are interconnected. Show up in unison with no conflicting messages. HIV research is a textbook story on leveraging stigma to lead to the future of research.
- HHS is pushing the notion of widespread fraud. All 15 states targeted are Democratic states. CMS released public data on Medicaid increases in personal care but not acknowledging population changes and increased needs. Yesterday, they made an unprecedented funding freeze to Minnesota. Usually there would be corrective action plans but never this. Narrative is that HCBS is fraud.
- 2025 was filled with announcements to which reactions have been 'they can't do that' but then it happens anyway. Treasury is the Medicaid payer, under authority of the Finance Committee. California or Illinois will be next. Last week CDC cut grants to four states, CA and IL among them. Is the administration serious about these cuts or is it just sending a message? Let them win the message.
- Data is important, but the human face is critical. Some of the very bad structural changes to Medicaid were left out due to personal stories of those with lived experience. Read the "Paragon Health Report" which offers a dangerous narrative and idea that Medicaid is unlimited, planting the seeds of block granting, which would be the death of Medicaid. Behavioral health will be first on the chopping block. Work at the state level and use data on the cost shift of cutting these services, so that people end up in institutional or inappropriate settings. Mention prior exemptions for these populations. We haven't even talked about ACA cuts.
- State work is vital. Florida cut AIDS Drug Assistance Program suddenly, so there was immediate advocacy at the state level, to add pressure to a related legal challenge, and push for the rulemaking process (and a committee meeting that didn't happen.) The states choose how to implement, so engaging there is critical.
- Congress still sees MI, SUD, and IDD as bipartisan areas. We might see changes in attitude related to rural areas. Medicaid worked well for our populations in the first

place. When there's time for reconciliation in a different direction, we will focus on reforms that make it better for those people.
- Many states love the CCBHC project. The idea of universal care is popular, and ACA and Medicaid cuts will harm the CCBHCs, which may motivate legislators. Never had trouble getting bipartisan support for CCBHCs, more concerned with protecting the FQHCs which operate in rural areas.
- Regarding threats to HUD, litigation is the only reason funds didn't disappear. All funding was about to be directed to short-term shelter and away from permanent supportive housing. Executive Order on vagrancy criminalizes homelessness, not aligned with the last 25 years of effort, calls for the same kind of advocacy as Medicaid. Most disturbing is that the admin ties together SUD, healthcare, and homelessness, calls for getting people off the streets and into hospitals, increases stigma with the message that SUD is despair beyond repair.
- We have hope from collaborations, national conferences, personal, community, and feeling part of something bigger than ourselves. We will get to the other side.

Diverse Paths, Shared Goals: The State of States in Disability and Mental Health Policy

Laura J. Kelemen, Director of Community Services, Niagara County, New York:

- Local Responsibility in a State-Run System. Most New York counties are conservative. Recent federal changes have united us, as county governments do not want the cost shifted to them.
- Separate agencies for MI, SUD, and I/DD, with separate commissioners, also separate from Medicaid agency. Similar challenges to all counties.
- Competing state and federal priorities: long term housing vs transitional; expanded harm reduction vs narrowing definition; reduced barriers vs increased access rules.
- NY Medicaid reconfigured services over a ten-year period to maximize funding (e.g., peer support.) Current policy challenges are admin burden, cost of technology when you want to keep small grass roots agencies. HR1 is a huge loss of funding.
- Want to develop and expand the crisis continuum. Those manning the lifelines should be seen as first responders. Building a prevention network.
- More barriers to housing than before. Focused on Housing First and long term supported housing. Housing stock is old, in poor condition, and not accessible. The short term rental market has reduced the stock in rural areas.
- Lack the workforce. Retention bonuses, inflationary increases, expanded state-led scholarship, tuition payment programs. laura.kelemen@niagaracounty.gov

Alan Bolter, Community Mental Health Association of Michigan:

- Election year dominates everything. Entire state legislature is up for election. Close split has contributed to historic inactivity over the last year. Budget season. $2bn less than anticipated last year, not just Medicaid cuts but also federal and state level tax changes, roughly $80bn total.

- HR1 impacts are trickling in, with implementation set to cost $100m. SNAP changes will cost another $100m. After that, provider tax cuts will start to hit the state.
- Governor proposed $800m in new 'sin' taxes to bolster Medicaid programs.
- Protect MI Care Coalition is a statewide advocacy effort to defend Medicaid and broader health care access.
- Some larger counties are considered partly rural, causing some trouble with fully rural counties competing for the Rural Health Transformation Program.
- Workforce Development & Retention is a key priority.
- PIHP Procurement changes. State ended up pulling the RFP and expects to release a new RFP but possibly not until 2027. Court outlined the roles and responsibilities of the local community mental health centers. Members are willing to improve the system but need to be at the table with the state, which is so far unwilling to work with them. Collaborating with NAMIs and other associations, to give policymakers unified recommendations. abolter@cmham.org

Ginny Palen, Minnesota Association of Community Mental Health Programs:

- Hard to keep up with the news, including last night's frozen funds.
- Map and state stats. Democratic governor, closely split Senate (34 to 33), 50/50 split House (67 to 67.) Due to the split in the house, it took six weeks to agree to how processes would be run, and the power divide continues.
- November forecast is $2.465 bn surplus in FY26-27, with a $2.960 bn projected shortfall in FY28-29. Add the Medicaid cuts, new claw-back, and ACA changes.
- Political assassinations of Speaker Emerita Hortman and her husband, attempt on Sen Hoffman and his wife. Federal administration's scrutiny of public programs. Federal immigration enforcement. Fraud claims have a racial component as do some immigration enforcement actions.
- Fraud allegations: 13 high-risk Medicaid benefits (adult day care, rehabilitative MH services, assertive community treatment, community first, companion care, individualized home supports, integrated community supports, early intensive developmental and behavioral intervention, night supervision, non-emergency medical transport, peer recovery, recuperative care, etc.)
- State response: Optum Health prepayment review on fee for service claims, payment withholding, certification/licensure moratorium, Optum vulnerability report (savings vs fraud dollars.)
- Federal response: $2bn withheld, mandate for corrective action plan and revised plan, CMS Medicaid provider enrollment moratorium. State of MN filed appeal for no withholdings. CMS mandated revalidation of Medicaid programs, with a huge cost of reorganization.
- Risk related to CCBHCs, which have been codified in the state plan amendment and have grown from 6 to 22 certified clinics. Rehab skill service program is among the 13 high risk programs. Trying to figure out how CCBHCs fit in within the provider-type issues. Working through legislative mechanisms to prevent further harm.
- Service programs' integrity - a cautionary tale: a rogue X account (inside sources) posting erroneous and harmful disinformation, which local politicians call a

whistleblower and use as evidence at hearings. CMS and White House got hold of some posts and are subpoenaing officials to appear before Congress. Hard to counter disinformation with facts, as folks choose to advance their narratives.

- HR1 impacts: longstanding provider tax, so these prohibitions will hurt. Reimbursement rates do not keep up with market, and, if updated, will impact the state budget. Mental health rates were updated last year, eliminating a legacy policy of 20% cutback for services by a masters/licensed professional - this was to be offset by a rate increase approved by CMS but no longer available.
- HR1 impacts: MinnesotaCare Eligibility Repeal - the provider tax was supporting a program for adults at 200% of federal poverty level, now backtracked.
- Good news: initial funding award through Rural Health Transformation Program, close to the request. 3% of the total is set aside for rural centers, including the development of crisis urgent care centers, technology, community intervention and postvention, and payment reform. jin.palen@macmhp.org

The Big Shift: Changes in the Federal-State-Local Relationship

Blaire Bryant, Legislative Director for Health Policy, NACO:

- Medicaid as a federal-state-local partnership: impact on health and wellbeing of residents in over 900 county run hospitals and 700 long term care facilities; map of 2022 federal medical benefits, with Illinois among states mandated to contribute.
- HR1 provisions monitored: Medicaid financing reform will cause funding losses through the provider tax reform and reductions in size of allowable state directed payments; coverage and eligibility changes (through which increased requirements add administrative burden) include cost sharing requirements (copays for those currently covered through Medicaid expansion), retroactive coverage, and community engagement requirements (work or volunteer 80 hours a month); program integrity changes, such as twice a year redeterminations, quarterly decreased status checks, limitations on eligible populations based on citizenship, and payment reductions when HHS audits find an error rate over 3%. Illinois is currently at 10%. A tighter window for error rates, despite 2029 implementation.
- Implementation dates: June 1, 2026 – HHS-CMS will release interim final guidance on work requirements; January 1, 2027 - work requirements for expansion enrollees, 6-month redeterminations, retroactive coverage of only 30 days; October 2028 - cost sharing for expansion adults over 100% of federal poverty level; October 2029 - payment error rate measurement changes.
- Provisions with funding for local governments: community engagement $200m in grants; HCBS waiver option $100m to states. Rural Health Transformation has another $200m already out. They were surprised to learn funding gets bottlenecked at the state level so maybe add provision for direct funding to local governments.
- Implications for county governments: increased staff for eligibility determinations; IT system upgrades; increased uncompensated care. Implications for hospitals, nursing homes, and healthcare providers: tighter operating margins; loss of rural hospitals; uncompensated care. Implications for Medicaid beneficiaries: more out

of pocket costs; loss of coverage. Implications for all residents: decrease in coverage options; out of pocket costs due to market instability; reduced proximity to care. The biggest impact on county budgets will be uncompensated care for 11.8m new uninsured patients. See NACo's report "The Big Shift" here (https://www.naco.org/resource/big-shift-analysis-local-cost-federal-cuts).
- Assess: impact on local health systems; resources (to implement requirements); data and IT infrastructure needs; and streamlining of integrity measures.

Jennifer Mathis, Deputy Director, Bazelon Center:
- Focus on people with any disability as we think about federal disability law. Biggest shifts are coming from HR1 and the Executive Order on crime and disorder. Short term housing. The 24-hour SAMHSA cut chaos. Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) on 'fraud'.
- Directive to HUD and HHS to defund many successful harm reduction programs. The recent Continuum of Care NOFO would have rescinded the Fiscal Year 24-25 approvals, shifted to transitional housing and excluded people with MI and SUD from permanent supportive housing, and set conditions on gender ideology and treatment versus a housing approach. Legal challenges reinstated the old NOFO, for now. Congress required renewal of these grants plus release of 2026 NOFO by June. Now HUD says the litigation should be moot, due to Congress' action, but the litigants disagree. If HUD takes this approach with other programs, causing significant loss of housing by people with disabilities (especially MI or SUD) and contributing to cycling through high cost inappropriate settings (e.g., jail, hospital).
- Not just thinking about good policy but also upholding ADA, Section 504. Plain language, helping people with applications, and considering a wide range of activities to constitute work may already be obligations under law. Maybe even allowing people with disabilities more time to meet requirements; a reasonable modification may be a few extra days. Disability Rights Laws apply even if people aren't receiving Medicaid. **ADA is not limited to Medicaid enrollees, so states still have obligations under Olmstead, and it is still cheaper to serve people in the community rather than institutional settings.**

Deborah Steinberg, Senior Health Policy Attorney at Legal Action Center:
- History of parity: Mental Health and Addiction Equity Act (2008) was a bipartisan, anti-discrimination law; 2013 federal regulations for private plans; 2016 federal regulations for Medicaid; 2020 parity act amended by congress; 2024 updated federal regulations; and 2025 ERISA Industry Committee lawsuit (federal non-enforcement policy and recent state enforcement.)
- Today, a new issue brief about parity, with red flag examples per state.
- States can elect to start enforcing work/volunteer reporting prior to January 1, 2027. Medicaid expansion population will have to do a combination of work, education, training, and community service for 80 hours a month. Exemptions: 'medically frail or otherwise has special medical needs' (blind, disabled by SSI definition, SUD, disabling mental disorder, physical or I/DD impairing 1 or more activities of daily

living, or serious or complex medical condition). If we are not told what it is, we can make it as generous as we want. A separate exemption for people in alcohol treatment and rehab program, as defined by statute, and this is only private non-profit facilities, so it's especially not helpful the day they leave treatment.

- To mitigate the harm of HR1, three guiding principles: maximize exemptions with broad definitions, finding the longest-term exemptions - e.g. being in treatment doesn't last as long as having an SUD; minimize burdens by finding best ways to show compliance, minimizing costs to the state; advance inclusive policies to improve access to care and coverage, aligning with our values rather than remaining in the exhausting defense mode.
- Three reports: "Protecting People with Substance Use Disorders and Formerly Incarcerated Individuals from Losing Medicaid Coverage"; "Work Reporting Requirements and Mental Health"; and "Protecting Individuals with HIV/AIDS from Losing Medicaid Coverage" are posted at www.lac.org with similar resources.

Discussion:

- Chaotic environment feels intentional as a wealth grab occurs 'behind' the scenes.
- Duality of the federal movement: first explicitly saying they want to give power back to states and local government; meanwhile a great deal of preemption, where the federal government is making decisions that override that local authority.
- Unusual collaborations emerge as all of our backs are to the wall, finding new allies and partners.
- Bipartisan interest in comprehensive behavioral health approaches and policy creates a lane of authority for IMD exclusion reform.
- Youth are giving hope; two recent GWU grads are here today and working in this space; this is not just a marathon, it's a relay race, requiring we pass the baton.

Homelessness, Housing, and Inpatient Services

Marcella Maguire, Director of Health Systems, Corporation for Supportive Housing:

- Homelessness is a Housing problem. Housing is not an entitlement. People with disabilities are the last to be supported.
- Housing Basics: Affordable Housing, as 30% of household income, with housing costs to include rent, utilities, renter insurance; Service-Enriched Housing, with some type of service attached to a building so that residents can easily avail themselves of those services; Supportive Housing, with services assigned to a person, and supports integrated at the person level. Mostly funded through the homelessness CoC system. People with behavioral health needs are overrepresented among those qualified. Great variation of services within models.
- No current cross federal department housing framework. People with low incomes and disabilities live in permanent settings (naturally occurring affordable housing, with family, HUD assisted, group homes, assisted living, nursing homes) or transitional/short term settings (peer run housing, recovery housing, state hospitals, nursing homes, carceral settings, sheltered or unsheltered homelessness.)

- Review of the many federal programs under HUD plus USDA rural. Funds generally move from federal directly to localities. States may have programs.
- Supportive Housing's 3-legged stool of financing: capital, services, and operating.
- Historical potential funding sources for these three pillars.
- This is a behavioral health concern because people with these disabilities are overrepresented among those experiencing housing instability, homelessness, and unsheltered homelessness. Project 2025 says that the reason people are homeless is that they are making bad choices. New and old data show good reason to connect resources for people with these complex needs.
- Focus on supportive housing shifts. The policy pendulum: from systems failure to individual/moral failure. Research over decades points to system failures, shows that supportive housing works and that rental costs, stagnant wages, and low housing stock are driving up homelessness.
- Special Needs Assistance Programs (SNAPs).
- Review of 2024 HUD National Report on Homelessness. CoF data.
- Executive Order "Ending Crime and Disorder on America's Streets."
- National Alliance to End Homelessness et alia versus US Dept of HUD et alia; two cases proceeding through Rhode Island federal court have merged; HUD requested emergency removal of the temporary restraining order to allow it to proceed with their December 2025 NOFO; expect a new order from the judge by March 2.
- Critical questions: target population; affordable to whom (income levels); how long is a person supported; service and staffing models; proactive or reactive services.
- More emphasis on short-term options and how much money for each service, each person, with 30 days to turn this on. Visible homelessness will rise, with pressure for short-term solutions. marcella.maguire@csh.org and www.csh.org

Michelle Cabrera, Executive Director, County Behavioral Health Directors Association of California:

- California's Point in Time Count was 187k people. Majority entering homelessness are over 50 and due to economic circumstances, such as job loss, health issues, lack/price of housing.
- Voters and business owners are not happy about the impact on quality of life. Some issues with state hospitals, primarily serving those with felony charges awaiting competency restoration, most of whom were unhoused at the time of arrest.
- Stats on affordability. Impact of sleep deprivation, as some people use meth to avoid the risk of being assaulted while asleep.
- Nearly 50/50 split of health care coverage (private is 55%). Medicaid carve-out of specialty behavioral services (managed care pays Per Member Per Month).
- Responsibilities of the county behavioral health safety net. Reliant on sales, vehicle licensing, and millionaire taxes.
- Led the way on involuntary treatment laws, with1967 bipartisan Lanterman-Petris-Short Act. Unfunded mandate delegated to counties. Decreased populations served at state hospitals, aligned with IMD exclusion.

- Intersection of involuntary treatment and homelessness: despite evidence, people believe that MH and SUD are causes of homelessness; lack of access to care in private insurance markets leads to families seeking greater access to involuntary treatment, so that people have to get very sick, rather than commercial plans being pressured to do their jobs; ACLU lawsuit required CA Dept of State Hospitals to address long wait time for competency restoration, and the state wanted to force counties to take this on.
- State Behavioral Health Reforms Impacting County BH - 90 new reforms since 2022. Each would be a big deal. Several of these link behavioral health to homelessness.
- Governor backed voter initiative, Prop 1 (which barely passed) policy shifts: requires new evidence-based practices but using the same money, and therefore serving fewer people. Estimated impacts to county funding when new allocations go live, reductions and shifts to cover increased housing costs. Housers asked how they could spend this money, but it is already spent.
- Federal funding sources are by far the greatest share of investments in housing. Because the state-county programs tend to have very low turnover and long term support obligations, the promise was in using Medicaid to add to the services.
- Homelessness is a Housing Problem.

Shelly Weizman, Center on Addiction & Public Policy O'Neill Institute, Georgetown Law:

- Federal changes: the Executive Order discussed earlier is a 180-degree turn, encouraging expanded use of civil commitment, directing the Department of Justice to reverse precedents and termination of consent decrees, linking federal posture to encampment enforcement and institutional pathways, and signaling a shift away from Housing First toward treatment-contingent models.
- Executive Orders do not override federal law or overturn case law or vacate DOJ agreements with state and local governments. A constitutional floor is set for civil commitment, with baseline requirements such as MI+ dangerousness, due process protections, not just status, integration of disability law, and state law expansion of requirements and processes.
- Civil Commitment for SUD. Different clinical realities, mortality risks, and system interactions from MI. In Illinois, co-occurring MI is required for involuntary commitment. Limited evidence of durable benefit to recovery without continuity of care; elevated risk periods around discharge without medications for opioid use disorder (methadone and buprenorphine) and housing. Outcomes depend heavily on quality of care and supports following discharge.
- Build Lived Experience into System Design!

NACBHDD Legislative and Policy Conference, Day 2

David Weden: welcome and overview and thank you to Jonah and Grace.

Rural Health Transformation

Accessing services in rural areas can be challenging. Obstacles include availability of providers, affordability, and acceptability of services. Recent policy developments including the Rural Health Transformation (RHT) Grant could help address these concerns.

Faith Parks, Vice Chair of NARMH, introduced the topic and panelists.

Kristin Martinsen, Senior Advisor, Federal Office of Rural Health Policy, HRSA:

- Review of HRSA and this Office, providing funding for rural health care. Voice for Rural, Capacity Building, and Cross Agency Collaboration. Supporting CMS in the RHT program will leverage existing resources in support of the state plans.
- Rural Communities Opioid Response Program is the only federal program dedicated to OUD and SUD exclusively in rural communities. Enacted in FY2018, currently at $145m. 210 current grantees, 938 recipients total since 2018. Behavioral Health NOFO this spring, FY2026 investment of $60m, with average awards of $750K.
- Several other community-based programs are flexible to enable communities to address their unique healthcare needs.
- Policy Briefs and one stop shop resource, with toolkits, funding opportunities, info on various issues are at https://ruralhealthinfo.org/
- Become a HRSA Grant Reviewer! www.HRSA.gov and kmartinsen@hrsa.gov

Dr. Carrie Cochran-McClain, Chief Policy Officer, National Rural Health Association:

- Journal of Rural Health. 21k members across the country. 45 State Rural health Associations, great resources, along with the state offices of rural health.
- Rural opportunity: addressing declining life expectancy and health outcomes; reducing rural healthcare workforce shortages; investing in strong health safety net.
- Advocacy areas include reauthorizing the Rural Communities Opioid Response program (HR6407), buprenorphine, telehealth, etc.
- The RHT Program has strategic goals for: population health, prevention/chronic disease, and behavioral health; fostering sustainable access through economic model, care delivery, and provider payments; workforce development by making rural areas more feasible for providers to reside; innovative care using value based payments and clinically integrated network; supporting technology innovation with technology-based solutions, training and technical assistance, and IT investments.
- $50bn over 5 years for all states with approved applications, through 2030. Baseline funding is 50%, and workload funding the other 50%. Every state received an award, from Rhode Island (smallest amount) to $281m for Texas. Strategies are flexible.
- 11 states listed mental/behavioral health as an initiative, and 35 have it as a strategy within a larger initiative. Lots of focus on telehealth and virtual care, school-based services, expanded MAT, EMS, mobile health, integrated network model/CCBHC.
- Will include 16 project officers throughout CMS regional offices to work with states.
- ccochran@ruralhealth.us and https://www.ruralhealth.us/advocacy

Don Hannaford, Vice President of Public Policy for Rural Minds:

- The only national nonprofit focused on advocating for rural mental health equity, promoting mental wellness, and providing information and resources to confront rural mental health challenges and the stigma. Founded by Jeff Winton, a dairy farmer in upstate New York whose nephew died by suicide.
- Our rural mental health emergency: suicide rates are 49% higher than those in large urban areas; the highest rate of suicide of any profession, farmers are 3.5 times more likely than general pop.
- Barriers: few mental health providers, 81% do not have a psychiatric nurse practitioner; 20% fewer primary care providers than in urban counties; and 28% rural residents do not have broadband internet.
- A small organization with many partnerships. Insight into MI stigma in rural US.
- Rural Mental Health Resilience - A Program of Hope providing resources through various means, addressing the depression caused by isolation, with a pilot program on youth MI (partnered with FFA, 4H, Cornell/New York FarmNet, the National Grange) to identify unmet needs or gaps in information and resources.
- Rural Veterinarian Profession Sustainability Program, to expand efforts to equip students for challenges of rural veterinary careers, and leverage resources.
- Closing the Mental Health Gap Among Rural Youth in the US - podcasts and video.
- www.RuralMinds.org

Discussion:

- Use catalyst funding to replicate best practices. RHT funds will help build capacity for the training programs to sustain the workforce and effective services.
- Data show that those trained in rural areas are likely to stay and that people from rural areas are more likely to return to practice. Expand workforce with Community Health Workers and Peer Supporters. Allied health and paraprofessional expansions in many proposals. 38 states had 'grow your own' capacity.
- Youth are beginning to stay rural.
- People don't want to go to a mental health clinic because everyone recognizes their truck - another reason for telehealth and virtual care and why we need connectivity.
- Recent policy developments focus heavily on technology. Digital literacy to improve access, from provider and patient perspective. Collaborate to maximize the investment. Many states' applications focused on digital access, but the whole billion can't be used to lay broadband across your state. If the end user doesn't know how to use this, no gain. Advocate for continued audio only option. Many in ag are very capable of mastering these technologies, as are the youth, so literacy is not as great a challenge as access and affordability of broadband.
- Youth should be at the table for planning, as should people providing and receiving services, so that this is not an urban model being pushed on rural residents.
- The initial lead person has to be in state government; some states are running the steering committee, others contract with a partner (e.g., community foundation.)
- Bilingual services where immigrants are critical to ag and related industries.

- Regarding moral injury and loneliness, digital tools may be a bandaid which exacerbates this. Geography is a challenge.

Workforce Crisis: Bridging the Gap in Behavioral Health and I/DD Care

Dr. Gina Lasky, Senior VP of Care Delivery and Operations, Health Management Associates:

- Historical focus in a subset of the population, now responsible for all, as all things have become behavioral health.
- Relying on old therapy models, outpatient care. Productivity is a problem, and the same approach/system is attempting to provide care across the range of intensity and complexity of needs. All of this is in the background of the higher and higher demand for BH with decreasing funding.
- Workforce Solutions Partnership (Council on Behavioral Health Leadership, Health Management Associates, and National Council on Mental Wellbeing): create, identify, scale solutions; reimagine the workforce of the future and remove barriers.
- The approach requires broad cross-sector collaboration because "levers of change" include regulation and policy, quality and accountability, organizational culture, technology, workforce expansion, clinical model, and payment.
- Workforce Solutions Jam - virtual townhall every month, with many sectors joining the fast paced conversations. All 50 states represented. Many many presenters.
- Ideas discussed so far: Innovation in work (four-day work week). Building resilience (address secondary trauma). AI to reduce paperwork burden. Improve data measurement and monitoring. Innovation in lived experience (not just engagement).
- https://www.leaders4health.org/workforce-solutions-partnership-workforce-solutions-jam/

Deborah C. Baker, American Psychological Association:

- Psychology and interjurisdictional practice. Legal, regulatory, marketing issues.
- Psychologists have long practice across jurisdictions (before telehealth became common). Also some regular intermittent in person care across state lines. But state licensing laws govern practice - had been some interstate agreements, but states not eager to give up their authority.
- Partnered with association of state licensing boards (and another) for guidance on telehealth. Regulatory pathway, then risk management guidance for insurance.
- Not all states have temporary practice permissions (Illinois does not.)
- Pandemic was the catalyst. Stakeholder group considered multi-state licensure compacts. By 2019, a dozen states had signed on, and psychologists had been very lukewarm about telehealth and the risks - they had to pivot quickly. Another 30 states agreed to the compact, with only California, Oregon, and Louisiana, plus Guam, Puerto Rico, and US Virgin Islands not signing on.
- PSYPACT operationalized strategies to increase access of the existing workforce. Tele-practice track, with no time limit and temporary in-person track, up to 30 days in a year. For tele-practice, declare your state as the hub and practice in all states in the compact, but if you have a second home or office in a different state, you need

licensure there too. Also need to comply with each state's requirements and protocols (duty to warn, abuse/neglect reporting.) Receiving states can issue 'encumbrance' or adverse action on the PSYPACT credential and disclipine the provider (suspend license) which then ends that providers' ability to practice across participating states, while home state maintains oversight of the provider's license.

- Over 18k psychologists credentialed to participate in the 43 US jurisdictions. https://www.verifypsypact.org/PsypactDirectory
- An emerging alternative pathway is in 5 states registries of out of state providers. Washington State and DC have Uniform Telehealth Act.

Dina Kastner, Public Policy and Advocacy Manager, National Association of Social Workers:

- About NASW, which has 53 chapters.
- Health Care Policies: protecting Medicaid; Medicare access and reimbursement; social work safety (and violence prevention); student loan debt relief; telehealth.
- Dept of Ed Notice of Proposed Rulemaking on Student Loans: statutory background (HR1 established that grad programs and professional programs would have loan limits, then used 34 CFS 668.2 to designate professional, and then in rulemaking they limited it to a set which does not include many); substance of the rule (limits to grad programs are $20,500 annual and $100k aggregate, professional limits are also low); adds hardship to pursuing a degree, increasing shortages.
- Advocacy opportunities - comment period ends March 2.
- https://www.regulations.gov/document/ED-2025-OPE-0944-0001
- dkastner.nasw@socialworkers.org

Jonah led the panel discussion:

- Behavioral health is overregulated and underfunded compared to traditional healthcare, contributing to the workforce shortage. Very fragmented, esp as mental health is a carve out.
- Shift from individual to group therapy might increase efficacy of the workforce. Eco-cycle planning shows how we get stuck in rigidity traps. Innovations (send GROW to the Workforce Solutions Jam) - must look at solutions from other countries.
- Another consequence of the loan limits will be that medical students choose more well-paying areas than psychiatry.
- Overregulation also stops reciprocal training and protections against litigation.
- Expectations of risk management are a cultural problem, that the community cannot manage all the risk. Advocate for federal fellowships (ended by Reagan.)
- Opportunities and rays of hope for the I/DD and Behavioral Health workforce? Lots of passion. Can be difficult to find placements for licensed supervision but could be expanded. CCBHCs have good data and are showing good results on staff retention. States are working on licensing structure, including for rural and non-traditional workforce - building a more community-based and representative workforce. Show that impact. Social work looks at the whole person within their community.

Lunch & Coffee Chat

Chuck Ingoglia, MSW, President and CEO, National Council for Mental Wellbeing:

- Current policy landscape, some good things happening but lots of unexpected new challenges. Need new skills and ways to engage. Fear about HR1. When the SAMHSA cuts came up, people did not talk about laying off staff but rather about loss of services. Hospitals got involved in the pushback (contacting legislators) because they know how these cuts will impact them.
- Lean into our relationships with decision makers. Helps them to forecast too.
- Next chapter of CCBHCs as more states come online. Part of the motivation was to align purposes of the services with funding, also relationship to federal law. When FQHCs were getting additional funds (under Bush admin), community mental health centers were not - because to the federal government they didn't exist; having the place in federal law now helps. There is momentum and SAMHSA priority support. CCBHC program grants were not targeted in that SAMHSA cut threat.
- Expect president's budget to look like last year's, which Congress didn't agree with, even increasing some program funding. Take steps now to ensure access to care: reduction of paperwork and data collection. Bipartisan support is cause for hope.

The Crisis Continuum: Funding, Awareness, and Coordination

James Wright, Acting Director, Crisis Care Coordinating Office, SAMHSA:

- 988, Crisis Care System overview/history.
- Successfully transition to 988, with increased access (over 8m). Phone, chat, text, and videophone. 50% of states passed appropriations to fund 988 related services.
- Enhanced local crisis care continuum and improved technology (geo-routing for more local response.) Bolstered cybersecurity. Created 38 Training and Technical Assistance Centers. Brought US jurisdictions together for a convening.
- Federal funding from 2007 to 2025 (48k contacts in 2005). In 2022, 85% of funding needed to go to local centers, to build the workforce and other capacity. Call volume continues to increase. Some expansions at the state level.
- Coordination Activities, four different Cooperative Agreements.
- Re-released national guidelines, need to improve the quality of behavioral health crisis care nationally. Expanding into quality metrics.
- https://reimaginecrisis.org/ has maps and reports. samhsa.gov/988 www.988lifeline.org and https://988crisisystemhelp.samhsa.gov/

Michael T. Compton, MD, MPH, Professor of Psychology, Columbia University:

- Research project "How States Leveraged Federal Funding Mechanisms..." (funded by Pew Charitable Trust), looking at 9 mechanisms. Societal Backdrop and Legislative Backdrop (2014-2024). Section 9813 of ARPA allowed states to use the option for 85% federal match.
- On average, states submit 20 state plan amendments per year - 10,951 submitted over those 11 years, with some states more active (California had 421). They categorized them as having low, medium, or high impact on crisis services.

- CMS incentive to expand crisis services: 20 states got Mobile Crisis Planning grants.
- SAMHSA mental health services block grants are 0.4% to 5.3% of a state's total state mental health agency expenditures. 5% crisis set-aside in 2023 block grants were 0.04% to 0.4% of these budgets.
- Research project - national survey of mobile crisis programs. Closing data collection tomorrow. 69 responses from Illinois; only California had more, with 94.
- Finished a seven site, randomized control trial of CIT responses by police officers. Been studying this work for twenty years.
- A National Strategic Research Framework to Decriminalize Mental Illinois: "Entangled: How People with Serious Mental Illness Get Caught in Misdemeanor Systems" Book and Sozosei Lab to create infrastructure, etc.

Tia Dole, PhD, Chief 988 Suicide and Crisis Lifeline Officer, Vibrant:

- Has made a huge impact, from 48k in 2005 to 7.8m routed in 2025.
- 988 requires 170 activities. Crisis Centers need to be supported; connect to state entities; develop the crisis continuum; the public/contact.
- 17,785,000 988 contacts through July 2025. Even with a little bit of advertising, there is huge engagement, so the States have to get involved.
- 98% of people felt helped by the 988 call. 88% said it prevented them killing themselves. Less than 15% need a follow-up, which can flip our workforce issue.
- Go beyond the idea of clinicians; best crisis counselors are trained for these calls.
- 988 and AI current state and opportunities - people ask if this is an actual person (concerned that they're speaking to a bot - they don't want this). BUT there are some capabilities we want to use, esp around quality improvement training (call monitoring of chat/text for targeted performance feedback and counselor coaching; using a bot to play the person in crisis.)
- 988 and 911 integration around whole person care. 911 doesn't want to transfer calls to 988 due to liability - we don't want behavioral health to go to 911 because we don't want police to show up.
- Keep coming back to the help-seeker. Young people and partners give Tia Dole hope.

Hanna Wesolowski, Chief Advocacy Officer, NAMI:

- 49 state organizations and over 650 affiliates. Focus on advocacy and awareness. Every person in a mental health crisis deserves a mental health response.
- Created "Reimagine Crisis Response" – http://ReimagineCrisis.org – and has convened many partners. Local NAMIs are a resource.
- 9 polls asking about 988 awareness and other crisis response topics. Review these and more at http://nami.org/988
- 85% of Americans agree about an MH response rather than police response.
- 86% agree that young people should know about 988 and services.
- Women and queer people are more likely to be aware of 988.
- Half of Americans consistently prioritize immediate access to crisis counselors when contacting 988, so we need to make sure there are enough workers.

Laura Evans, Senior Vice President of Strategy, Communications, and Government Affairs at Recovery Innovations International:

- The State of Crisis Receiving and Stabilization: 495 CCBHCs in 46 states, with 24/7 facilities available to anyone. 82% reduction in risk to self. Less than 5 minutes first responder drop off time. Saved $1.8k in avoided hospital costs per encounter.
- Lower acuity, crisis respite, peer support, living room. Service intensity needs to match. Half of staff are peers - 82% reduction in high risk of harm. Prior to these options, law enforcement could spend hours in hospital waiting areas. Saving nearly $2k per encounter - put the money into crisis stabilization first!
- Crisis Jam is a weekly zoom meeting. No Wrong Door is the goal.
- Considerations: EMTALA and parity enforcement; payors, low reimbursements, and cost shift, not just adding a levy; care traffic control coordination because systems need to talk to each other - performance dashboards; impact on individuals and communities, with people saying this is the best care they've had.
- System Design and Service Delivery - GPS enabled mobile response; real-time bed registry; 24/7 outpatient scheduling. Need federal, state, and local funding, coordinated crisis continuum, and more. https://riinternational.com

Jonah led the panel discussion:

- A big challenge is cultural - how should we treat our neighbors, how should this country spend money - so let's not forget what happened during COVID.
- Bipartisan support for mental health. Invest more, since COVID turned more attention to mental health, but still not enough funding.
- Concern the pendulum will swing away again. NAMI members are afraid of loss of insurance coverage. Only $15m more (federally) into crisis this year, and people might have nowhere to go but crisis care.
- Moving away from law-enforcement-only crisis response is a very good thing.
- The fourth neglected element of crisis care is transportation.
- Might be easy to stop right here and leave the rest to states and localities, but with 15m new contacts, there has to be a place to go; a window now to maintain this momentum and blend the systems.
- Federal workers are dedicated to health, some at their own personal expense. Opening another site in North Carolina. Advocates living the worst of our system are still working for something better for others, not giving up. Lots of research results and upcoming analysis. Building this 988 system for our children.

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY d/b/a CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD (CCDDB)

BY-LAWS

Adopted by the CCDDB 1/4/05. Amended 12/5/06 and 7/23/14 and 6/23/2021 and 1/22/2025.

I. PURPOSE AND FUNCTIONS:

A. The Champaign County Developmental Disabilities Board (CCDDB) is established under the Illinois Community Care for Persons With Developmental Disabilities Act (IL Compiled Statutes, Chapter 50, Sections 835/0.01 to 835/14 inclusive) in order to "provide facilities or services for the benefit of its residents who are persons with intellectual or developmental disabilities and who are not eligible to participate in any such program conducted under Article 14 of the School Code, or may contract therefor with any privately or publicly operated entity which provides facilities or services either in or out of such governmental unit."

B. In order to accomplish these purposes, the CCDDB performs the following functions:

1. Planning for the intellectual and developmental disabilities services system to assure accomplishment of the CCDDB goals.

2. Allocation of local funds to assure the provision of a comprehensive system of community based intellectual and developmental disabilities services.

3. Coordination of affiliated providers of services for individuals with intellectual and/or developmental disabilities to assure an inter-related accessible system of care.

4. Evaluation of the system of care to assure that services are provided as planned and that services are effective in meeting the needs and values of the community.

C. The CCDDB shall perform those duties and responsibilities as specified in Sections 835/0.01 to 835/14 inclusive of The Community Care for Persons with Developmental Disabilities Act.

D. Nothing in these By-laws alters the authorities and obligations codified in state or federal law.

II. MEMBERSHIP:

A. The membership of the CCDDB shall include the maximum allowed by statute.

B. The members of the CCDDB shall be appointed by the presiding officer of the Champaign County Board, with the advice and consent of the Champaign County Board and its Personnel Committee. The CCDDB may recommend nominees for membership. Candidates apply through the County's publicly announced process.

C. Members of the CCDDB shall be residents of Champaign County and, as nearly as possible, be representative of interested groups of the community concerned with developmental disabilities, as well as the general public. No member of the CCDDB may be a full-time or part-time employee of the Illinois Department of Human Services - Division of Developmental Disabilities (DHS/DDD) or a Board member or employee of any facility or service operating under contract to the CCDDB. The term of office for each member shall be three (3) years. All terms shall be measured from the first day of July within the calendar year of appointment. Vacancies shall be filled for an expired term in the same manner as original appointments.

D. Any member of the CCDDB may be removed by the appointing officer.

III. MEETINGS:

A. The CCDDB shall meet, at a minimum, annually in July. The CCDDB may meet each month as necessary at such time and location as the CCDDB shall designate. Per the Open Meetings Act (5 ILCS 120/1 et seq.), a change in the regular meeting dates is to be properly posted for the public a minimum of 10 days prior to the meeting.

B. The CCDDB may meet in Study Session during the intervals between monthly meetings to receive reports, discuss issues, and develop recommendations on matters brought to it by the Executive Director and the President.

C. Special meetings may be called by the President or upon the written request by any member to conduct such business that cannot be delayed until a regular meeting date. The purpose of the meeting may be to address matters brought by the Executive Director or any member of the CCDDB.

D. The Executive Director shall prepare an agenda for all meetings of the CCDDB and shall cause the notice of the meeting and the agenda to be sent to all members at least five (5) days in advance of the meeting - except in the case of special/emergency meetings wherein forty-eight (48) hours' notice shall suffice.

E. Public notices and the conduct of all meetings shall be in conformance with the Illinois Open Meetings Act. Notice/agenda for each meeting shall be posted on the Champaign County website and in the physical location of the meeting and shall be

continuously available for public review during the 48-hour period preceding the meeting.

F. The presence of a majority of members shall constitute a quorum for any meeting of the CCDDB. For a member to attend a meeting by other means than physical presence (e.g. by video or audio conference), a majority of members must be physically present at the properly-noticed meeting, and a majority of physically present members must agree to allow the electronic attendance. Such attendance may only be due to: personal illness or disability; employment purposes or CCDDB business; unexpected childcare obligations; or a family or other emergency. A member wishing to attend a meeting by other means must notify the Board before the meeting unless advance notice is impractical. Provisions for a quorum of members to attend the meeting by other means, due to a declared disaster, are set forth in the Illinois Open Meetings Act. These By-laws affirm the Developmental Disabilities Board's intent to exercise flexibilities as the law allows.

IV. OFFICERS:

A. The officers of the CCDDB shall be a President and a Secretary.

B. Election of the officers shall take place at the July meeting of the CCDDB.

C. Officers shall be elected for one year, with term beginning upon election and ending no later than August 1 of the following year. No member shall hold the same office for more than three (3) consecutive years, except that officers may remain in their then current positions until their successors can be chosen.

D. Duties of Officers:

1. President:

   Subject to the control and direction of the CCDDB, the President shall maintain a current general overview of the affairs and business of the CCDDB. The President shall have the privilege of voting in all actions by the CCDDB.

2. Secretary:

   The Secretary shall act in place of the President in the latter's absence. The Secretary shall attest to the accuracy of the minutes of the CCDDB meetings.

3. The President, Secretary, or a member as designated by the President shall have the authority to sign all legal documents approved by the CCDDB.

4. The President may make, with the advice and consent of the CCDDB, temporary appointments of interested citizens to assist the Board in fulfilling designated responsibilities or to perform certain functions or tasks.

V. STAFF:

The CCDDB shall engage the services of an Executive Director who, subject to the control and direction of the Board, shall have general charge, oversight, and directions of the affairs and business of the CCDDB and shall be its responsible managing head. The Executive Director shall have the responsibility for the employment and discharge of staff pursuant to the provisions of applicable personnel policies. The Executive Director shall have the authority to sign on behalf of the CCDDB all necessary papers pursuant to CCDDB action and shall have the authority with the endorsement of the President to make contracts and expenditures within the approved program and budget. The Executive Director or delegate shall attend all meetings of CCDDB. The Executive Director shall also be liaison between the CCDDB, staff, and affiliated agencies and implement policies regarding communications between them.

VI. FISCAL AND GRANT YEARS:

A. The fiscal year of the CCDDB shall be the same as that of the County of Champaign, i.e., January 1 through December 31.

B. CCDDB contracts for Intellectual and Developmental Disability programs and facilities shall be for the same fiscal year as the State of Illinois, i.e., July 1 through June 30.

VII. RULES OF ORDER:

"Roberts' Rules of Order" shall be followed in deliberations of the Board unless otherwise precluded by these By-laws.

VIII. CHANGE OF BY-LAWS:

Any or all of these By-laws may be altered, amended or repealed by a majority vote of the Board at any regular or special meeting, provided that written notice of the proposed action is given in the call to the meeting and that a quorum is present.

CCDDB and CCMHB I/DD Funding Requests for PY2027 (July 1, 2026-June 30, 2027)

Priority Category	*Agency Name*	*Program Name*	*Approved CCDDB PY26*	*Approved IDDSI PY26*	*Approved CCMHB PY26*	*All Fund Requests for PY27*	*Percentage Change if continuing*	*Primary and Secondary Reviewers*
Advocacy and Linkage	CCRPC - Community Svcs	Decision Support PCP	**$425,042**			**$505,565**	19%	SF/KF
Advocacy and Linkage	DSC	Service Coordination	**$500,000**			**$538,500**	8%	NS/AR
Home Life	Community Choices, Inc.	Inclusive Community Support	**$233,000**			**$246,000**	6%	KF/NS
Home Life	DSC	Community Living	**$628,000**			**$646,000**	3%	SF/DG
Personal Life	Community Choices, Inc.	Transportation Support	**$243,000**			**$261,000**	7%	AR/NS
Personal Life	DSC	Clinical Services	**$263,000**			**$264,700**	1%	DG/SF
Personal Life	DSC	Individual & Family Support	**$320,000**			**$329,000**	3%	KF/DG
Personal Life	PACE	Consumer Control in Personal Support	**$45,972**			**$45,972**	0%	DG/KF
Work Life	Best Buddies International	Best Buddies Jobs - NEW	**n/a**			**$100,000**	NEW	AR/SF
Work Life	Community Choices, Inc.	Customized Employment	**$256,000**			**$267,500**	4%	NS/KF
Work Life	DSC	Community Employment	**$523,000**			**$540,200**	3%	SF/AR
Work Life	DSC/Community Choices	Employment First	**$102,500**			**$106,000**	3%	DG/KF
Community Life	Community Choices, Inc.	Self-Determination Support	**$228,000**			**$239,000**	5%	AR/DG
Community Life	DSC	Community First	**$990,000**			**$1,035,000**	5%	NS/AR
Community Life	DSC	Connections	**$122,000**			**$125,500**	3%	SF/NS
Community Life	CCRPC	Community Life Short Term Assistance		**$232,033**		**$0**	n/a	n/a
Strengthening the I/DD	Community Choices	Staff Recruitment and Retention	***$48,000***			***$48,000***	n/a	*2 yr - no review*
Strengthening the I/DD	DSC	Workforce Development and Retention	**$244,000**			**$287,310**	18%	KF/SF
Young Children and thei	DSC	Family Development			***$702,000***	***$702,000***	n/a	*2 yr - no review*
	Head Start/Early Head Start	Early Childhood MH Svs (MH & DD)			**$216,800**	**$411,062**	DD portion TBD	AR/NS
	CU Early	CU Early (MH &DD)			**$16,145**	**$86,701**	DD portion TBD	NS/AR
		(amounts listed are for DD portion of MHB contracts)			-	-		
			$5,171,514	**$232,033**	**$934,945**	**$6,785,010**		
			Total PY26 awards = $6,338,492			*Total PY27 requests. MHB could award $964,863 (3.2% increase)*		

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Program Year 2025 Service Activity Data Briefing Memorandum

DATE: March 25, 2026
TO: Champaign County Developmental Disabilities Board (CCDDB)
FROM: Kim Bowdry, Associate Director for Intellectual and Developmental Disabilities
SUBJECT: Program Year 2025 Service Activity Data

Background

At the beginning of Program Year 2018, a new data collection system for programs serving people with I/DD was put into practice by CCDDB staff. Many funded programs began entering service claims into the Online Reporting System for the types of services provided to people served. Since this practice started, agencies have continued providing a higher level of detail about client specific service activities than in prior years.

Prior to the beginning of Program Year 2021 the reporting categories used by agency staff were changed at the request of a CCDDB member. The focus of the new categories was on a client's presence with staff during the time entered as a claim and where the activity took place. These new claims were entered as 'With Person Served' or 'On Behalf of Person Served.' Both new service options could be associated with one of the following place options, 'Off Site (in the community or client home)' or 'On Site (at an agency facility)'. At this time units of service were changed from quarter hour entries to full hour entries. While using full hours of service may, in some cases, give an appearance of over service, it provides a more accurate description of service and was also meant to prevent burdening agency staff with excessive data entry. This method of reporting was also meant to provide a more accurate representation of the services provided by CCDDB funded programs than prior to Program Year 2018.

CCDDB Funded Program Information

The 'Utilization Summaries for Program Year 2025 CCDDB and CCMHB I/DD Programs' document is attached for reference. This document was included in the October 22, 2025, CCDDB packet. Programs listed below reported service activity data for specific people served. Program Year 2025 totals are listed by program.

CCRPC

- Community Life Short Term Assistance served 32 people for a total of 491 hours, with total payments of $232,033, and $157,195 returned as unspent revenue.
- Decision Support Person Centered Planning served 102 people for a total of 6,354 hours, with total payments of $418,845.

Community Choices

- Community Employment served 53 people for a total of 3,176 hours, with total payments of $239,500.
- Inclusive Community Support served 36 people for a total of 2,584 hours, with total payments of $213,000.

DSC

- Clinical Services served 78 people for a total of 1,587 hours, with total payments of $260,000, and $15,274 returned as unspent revenue.
- Community Employment served 82 people for a total of 8,041 hours, with total payments of $500,000.
- Community First served 59 people for a total of 38,555 hours, with total payments of $950,000.
- Community Living served 74 people for a total of 16,699 hours, with total payments of $615,000.
- Connections served 32 people for a total of 2,525 hours, with total payments of $115,000, and $858 returned as unspent revenue.
- Individual and Family Support served 39 people for a total of 8,043 hours, with total payments of $308,000, and $76,354 returned as unspent revenue.
- Service Coordination served 251 people for a total of 7,929 hours, with total payments of $520,500, and $50,276 returned as unspent revenue.

PACE

- Consumer Control in Personal Support registered 35 Personal Support Workers (PSWs), with total payments of $45,972. The program also matched 4 PSWs to people with I/DD who were seeking PSWs.

As in previous years, not all programs reported client level data as claims in the Online Reporting System. These programs are listed below. Two programs serve a significant number of Non-Treatment Plan Clients and do not report client level data on these services. For the programs below, this information can be found in the attached 'Utilization Summaries for Program Year 2025 CCDDB and CCMHB I/DD Programs' document.

Community Choices

- Self-Determination Support, $213,500
- Transportation Support, $171,000

DSC

- Employment First, $98,500. $6,538 was returned as unspent revenue.

Programs and People with Service Level Data

- Of the programs reporting on specific individuals and service activities, there were 380 unduplicated adults or older children and 668 young children.

- Of the unduplicated adults and older children served during Program Year 2025, 54% had state waiver funding as well, due to billing restrictions through Illinois Department of Human Services Division of Developmental Disabilities waiver programs.

- Of the unduplicated adults and older children served during Program Year 2025, 46% had CCDDB/CCMHB funding only.

- An individual may receive services from more than one agency and more than one program within a single agency. All adult TPCs in CCDDB funded programs should also be enrolled in CCRPC's Decision Support PCP program, receiving Conflict Free Case Management, or be enrolled in Medicaid waiver funded services. There was no overlap of adults or older children, and only 2 young children had a minor overlap in services.
    - 264 (259 in Program Year 2024) people were served by one agency only.
    - 103 (108 in Program Year 2024) people were served by two agencies.
    - 13 (3 in Program Year 2024) people were served by three agencies.
    - 160 people (156 in Program Year 2024) were served in one program only.
    - 99 (104 in Program Year 2024) people were served in two programs.
    - 55 (51 in Program Year 2024) people were served in three programs.
    - 32 (34 in Program Year 2024) people were served in four programs.
    - 19 (11 in Program Year 2024) people were served in five programs.
    - 9 (9 in Program Year 2024) people were served in six programs.
    - 5 people (3 in Program Year 2024) were served in seven programs.
    - 1 person (0 in Program Year 2024) was served in 8 programs.

Profiles of People Receiving Services from Multiple Programs

Involvement with multiple agencies and multiple programs is often appropriate for each individual person's service needs and preferences. The need or preference for multiple agencies and/or program involvement should be documented in each person's person-centered plan. Below is a summary of agency and program involvement during Program Year 2025.

- All 13 people served by three agencies were served by CCRPC, Community Choices, and DSC.

- One person who accessed eight programs was served by CCRPC Community Life Short Term Assistance and Decision Support PCP, DSC Clinical, Community Employment, Community First, Community Living, Connections, and Service Coordination.
- One person who accessed seven programs was served by CCRPC Decision Support PCP, Community Choices Customized Employment, Inclusive Community Support, DSC Community Employment (no overlap in services with CC CE), Community First, Connections, and Service Coordination with CCDDB funding only.
- Two people who accessed seven programs were served by CCRPC Community Life Short Term Assistance, Decision Support PCP, DSC Community Employment, Community First, Community Living, Connections, and Service Coordination with CCDDB funding only.
- One person who accessed seven programs was served by CCRPC Community Life Short Term Assistance, Decision Support PCP, Community Choices Customized Employment, DSC Clinical, Community First, Community Living, and Service Coordination with CCDDB funding only.
- One person who accessed seven programs was served by CCRPC Community Life Short Term Assistance, Decision Support PCP, Community Choices Customized Employment, DSC Community First, Community Living, Connections, and Service Coordination with CCDDB funding only.

- Of the 9 people served in six programs:
    - 9 people had CCDDB funding only.
    - 1 people were served by CCRPC Decision Support PCP, DSC Clinical Services, Community Employment, Community First, Community Living, and Service Coordination.
    - 1 people were served by CCRPC Community Life Short Term Assistance, Decision Support PCP, DSC Clinical Services, Community First, Community Living, and Service Coordination.

- 3 people were served by CCRPC Decision Support PCP, Community Choices Customized Employment (no overlap with DSC CE), DSC Community Employment (no overlap with CC CE), Community First, Connections, and Service Coordination.
- 1 person was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, Connections, and Service Coordination.
- 1 person was served by CCRPC Community Life Short Term Assistance, Decision Support PCP, DSC Clinical, Community Employment, Community Living, and Service Coordination.
- 1 person was served by CCRPC Community Life Short Term Assistance, Decision Support PCP, DSC Community First, Community Living, Connections, and Service Coordination.
- 1 person was served by CCRPC Decision Support PCP, DSC Clinical, Community First, Community Living, Connections, and Service Coordination.

- Of the 19 people served in five programs:
  - 17 had CCDDB funding only and two were selected from the PUNS list and working with Prairieland Service Coordination, Inc. (PSCI) to complete their Pre-Admission Screening for Medicaid Waiver funding.
  - 5 people were served by CCRPC Decision Support PCP, DSC Clinical Services, Community First, Connections, and Service Coordination.
  - 3 people were served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community First, and Service Coordination.
  - 2 people were served by CCRPC Decision Support PCP, DSC Community Employment, Community First, Connections, and Service Coordination.
  - 2 people were served by CCRPC Community Life Short Term Assistance, Decision Support PCP, DSC Community Employment, Community Living, and Service Coordination.
  - 2 people were served by CCRPC Decision Support PCP, Community Choices Customized Employment, DSC Community First, Connections, and Service Coordination.
  - 1 person was served by CCRPC Decision Support PCP, DSC Clinical, Community Employment, Community Living, and Service Coordination.
  - 1 person was served by DSC Community Employment, Community First, Community Living, Connections, and Service Coordination (selected from the PUNS list and engaged in the Pre-Admission Screening process with PSCI).
  - 1 person was served by DSC Clinical, Community First, Community Living, Connections, and Service Coordination (selected from the PUNS list and engaged in the Pre-Admission Screening process with PSCI).

- 1 person was served by CCRPC Decision Support PCP, Community Choices Customized Employment, DSC Clinical, Community First, and Service Coordination.
- 1 person was served by CCRPC Decision Support PCP, DSC Community First, Community Living, Connections, and Service Coordination.

Samples of Total Hours of Services by Program

Client level data can be found below. This data provides examples of how people with I/DD in Champaign County utilized the programs funded by the CCDDB for Program Year 2025. Each of the people with I/DD below received services using only CCDDB funding, i.e., they did not receive Medicaid Waiver funding for services.

- Person A participated in 8 programs with 2 agencies:
  - 34 hours of service from CCRPC Community Life Short Term Assistance, 7% of total program hours.
  - 93 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
  - 45 hours of service from DSC Clinical Services, 3% of total program hours.
  - 111 hours of service from DSC Community Employment, 1% of total program hours.
  - 537 hours of service from DSC Community First, 1% of total program hours.
  - 326 hours of service from DSC Community Living, 2% of total program hours.
  - 66 hours of service from DSC Connections, 3% of total program hours; and
  - 186 hours of service from DSC Service Coordination, 2% of total program hours.

- Person B participated in 7 programs with 3 agencies:
  - 52 hours of service from CCRPC Community Life Short Term Assistance, 11% of total program hours.
  - 40 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
  - 233 hours of service from Community Choices Customized Employment, 7% of total program hours.
  - 17 hours of service from DSC Community First, <1% of total program hours.
  - 162 hours of service from DSC Community Living, 1% of total program hours.
  - 1 hour of service from DSC Connections, <1% of total program hours; and
  - 64 hours of service from DSC Service Coordination, 1% of total program hours.

- Person C participated in 7 programs with 3 agencies:
    - 81 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
    - 23 hours of service from Community Choices Customized Employment (no overlap with DSC CE), 1% of total program hours.
    - 75 hours of service from Community Choices Inclusive Community Support, 3% of total program hours
    - 8 hours of service from DSC Community Employment (no overlap with CC CE), <1% of total program hours.
    - 344 hours of service from DSC Community First, 1% of total program hours.
    - 31 hours of service from DSC Connections, 1% of total program hours; and
    - 23 hours of service from DSC Service Coordination, <1% of total program hours.

- Person D participated in 6 programs with 3 agencies:
    - 83 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
    - 31 hours of service from Community Choices Customized Employment (no overlap with DSC CE), 1% of total program hours.
    - 17 hours of service from DSC Community Employment (no overlap with CC CE), <1% of total program hours.
    - 268 hours of service from DSC Community First, 1% of total program hours.
    - 100 hours of service from DSC Connections, 4% of total program hours.
    - 42 hours of service from DSC Service Coordination, 1% of total program hours.

- Person E participated in 6 programs with 2 agencies:
    - 63 hours of service from CCRPC Community Life Short Term Assistance, 13% of total program hours.
    - 56 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
    - 13 hours of service from DSC Clinical, 1% of total program hours.
    - 106 hours of service from DSC Community Employment, 1% of total program hours.
    - 411 hours of service from DSC Community Living, 2% of total program hours.
    - 27 hours of service from DSC Service Coordination, <1% of total program hours.

- Person F participated in 5 programs with 3 agencies:
    - 92 hours of service from CCRPC Decision Support PCP, 1% of total program hours.

- 48 hours of service from Community Choices Customized Employment, 2% of total program hours.
- 382 hours of service from DSC Community First, 1% of total program hours.
- 195 hours of service from DSC Connections, 8% of total program hours.
- 12 hours of service from DSC Service Coordination, <1% of total program hours.

- Person G participated in 4 programs with 3 agencies:
  - 120 hours of service from CCRPC Decision Support PCP, 2% of total program hours.
  - 25 hours of service from Community Choices Customized Employment, 1% of total program hours.
  - 16 hours of service from DSC Community Living, <1% of total program hours.
  - 28 hours of service from DSC Service Coordination, <1% of total program hours.

- Person H participated in 3 programs with 3 agencies:
  - 45 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
  - 107 hours of service from Community Choices Customized Employment, 3% of total program hours.
  - 4 hours of service from DSC Clinical, <1% of total program hours.

Samples of Total Hours of Services by Program by Client

Specific client level data can be found below for one client. This data provides a comparison of how one person with I/DD utilized programs funded by the CCDDB from Program Year 2018 through Program Year 2025. Program Year 2018 may show partial year reporting for some programs listed below as agencies transitioned to using the Claims System. Claims from Program Year 2018 through Program Year 2020 were reported as quarter hours, and reporting categories were more specific than the updated claims used since PY2021.

- Person I participated in 4 programs with 2 agencies during Program Year 2018 with CCDDB funding only:
  - 1.75 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
  - 126.25 hours of service from DSC Apartment Services (currently Community Living), 3% of total program hours.
  - 52.25 hours of service from DSC Community Employment, 4% of total program hours.

- 12 hours of service from DSC Service Coordination, <1% of total program hours.

- Person I participated in 4 programs with 2 agencies during Program Year 2019 with CCDDB funding only:
  - 3 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
  - 166 hours of service from DSC Apartment Services (Community Living), 2% of total program hours.
  - 86.5 hours of service from DSC Community Employment, 2% of total program hours.
  - 17 hours of service from DSC Service Coordination, <1% of total program hours.

- Person I participated in 5 programs with 2 agencies during Program Year 2020 with CCDDB funding only:
  - 20.5 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
  - 143 hours of service from DSC Apartment Services (Community Living), 2% of total program hours.
  - 10 hours of service from DSC Clinical, 1% of total program hours.
  - 46.5 hours of service from DSC Community Employment, 1% of total program hours.
  - 26.5 hours of service from DSC Service Coordination, 1% of total program hours.

- Person I participated in 5 programs with 2 agencies during Program Year 2021 with CCDDB funding only:
  - 28 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
  - 3 hours of service from DSC Clinical; <1% of total program hours.
  - 164 hours of service from DSC Community Employment; 4% of total program hours.
  - 208 hours of service from DSC Community Living, 2% of total program hours.
  - 62 hours of service from DSC Service Coordination, 1% of total program hours.

- Person I participated in 5 programs with 2 agencies during Program Year 2022 with CCDDB funding only:

- 34 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
- 2 hours of service from DSC Clinical; <1% of total program hours.
- 159 hours of service from DSC Community Employment; 4% of total program hours.
- 149 hours of service from DSC Community Living, 2% of total program hours.
- 26 hours of service from DSC Service Coordination, <1% of total program hours.

- Person I participated in 5 programs with 2 agencies during Program Year 2023 with CCDDB funding only:
  - 10 hours of service from CCRPC Decision Support PCP, <1% of total program hours.
  - 8 hours of service from DSC Clinical; 1% of total program hours.
  - 91 hours of service from DSC Community Employment, 1% of total program hours.
  - 106 hours of service from DSC Community Living, 1% of total program hours.
  - 26 hours of service from DSC Service Coordination, <1% of total program hours.

- Person I participated in 4 programs with 2 agencies during Program Year 2024 with CCDDB funding only:
  - 79 hours of service from CCRPC Decision Support PCP, 1% of total program hours.
  - 153 hours of service from DSC Community Employment; 2% of total program hours.
  - 203 hours of service from DSC Community Living, 1% of total program hours.
  - 22 hours of service from DSC Service Coordination, <1% of total program hours.

- Person I participated in 5 programs with 2 agencies during Program Year 2025 with CCDDB funding only:
  - 1 hour of service from CCRPC Community Life Short Term Assistance, <1% of total program hours. Opened to the program at the end of the Program Year.
  - 99 hours of service from CCRPC Decision Support PCP, 2% of total program hours.

- 137 hours of service from DSC Community Employment; 2% of total program hours.
- 329 hours of service from DSC Community Living, 2% of total program hours.
- 95 hours of service from DSC Service Coordination, <1% of total program hours.

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Summary Results of PY2025 CCDDB, CCMHB, and IDDSI Funded I/DD Programs

Glossary and Notes

Detail on each program's performance toward defined consumer outcomes during the funding year of July 1, 2024 to June 30, 2025 is available at http://ccmhddbrds.org, among downloadable public files toward the bottom of the page and titled "CCDDB-IDDSI-CCMHB I-DD PY2025 Performance Outcome Reports." It is also posted here on the County website and includes many interesting and important observations and details not captured in this overview.

TPC = Treatment Plan Client
NTPC = Non-Treatment Plan Client
CSE = Community Service Event
SC = Service Contact or Screening Contact
Other, as defined in individual program contract

*4th Quarter Financial Reports indicate that unspent funds may be returned after agency audits/financial reviews are completed.

Priority:
Advocacy and Linkage

Champaign County Regional Planning Commission Community Services

***Decision Support Person Centered Planning** $425,042*

Services: Conflict-free case management and person-centered planning, transition from high school to adult life, identification of desired supports (for future system planning), and case management services for dually diagnosed adults. Outreach to high school professionals and families before IEP meetings to offer transition planning services for people with I/DD nearing graduation from secondary education. Staff attend scheduled events in the community to engage underserved populations, providing opportunities for preference assessment. Online survey opportunities and focus groups are used to gather data from people about service preferences. Dual Diagnosis Case Manager utilizes evidence-based approaches to increase service engagement. Case Manager works with clients on development/achievement of desired goals.

Utilization targets: 145 TPC, 30 NTPC, 100 SC, 25 CSE.
Utilization result: 99 TPC, 43 NTPC, 314 SC, 46 CSE, 6,354 hours of service.

Outcome 1 target: 3% increase in community referrals for students.
Outcome 1 result: 18% increase in IEP participation by transition consultant.
Outcome 2 target: link dual dx clients with outpatient MH support of client's choice.
Outcome 2 result: 100% of clients who were not already receiving MH supports were connected to local MH providers through referrals.
Outcome 3 target: 95% of clients working with PCP case manager will have current person-centered plans with at least one outcome.

Outcome 3 result: 99% of clients have current Discovery tool and PCP with one or more outcome.

DSC

***Service Coordination** $500,000*

Services: Works with ISC to develop Personal Plans and Implementation Strategies for county-funded and waiver participants. Supports people to be as active as possible in the development of their plan and to speak up for what they want. Offers intake screening; advocacy; assessments; medical support; crisis intervention; 24-hour on-call emergency support; referral and collaboration with other providers; linkage to services; apply for and maintain enrollment in SSDI and SSI and "Extra Help"; coordinate and assist with Medicare eligibility and enrollment; Representative Payee support; access tax professionals for filing federal and state taxes; legal support; and housing support.

Utilization targets: 275 TPC, 5 NTPC, 20 SC, 2 CSE.
Utilization result: 277 TPC, 2 NTPC, 24 SC, 2 CSE, 7,929 hours of service.

Outcome 1 target: 98% will participate in development of personal outcomes driving implementation strategies.
Outcome 1 result: 98%.
Outcome 2 target: 20 will participate in Personal Outcome Measure interviews.
Outcome 2 result: 15 (due to limited staff resources.)
Outcome 3 target: 90% of people will be satisfied with support from SC.
Outcome 3 result: 88% satisfied with services, 100% felt respected by Service Coordinator.

Priority:
Home Life

Community Choices

***Inclusive Community Support** $233,000*

Services: Housing, skills, connections, resource coordination, benefits and budget management, health, daily life coordination, and comprehensive HBS administration. Services chosen after in-depth planning process, in 1 of 3 tracks. Family-Driven Support: planning process for self-directed community living. Sustained Community Supports (ala carte): choice of services and supports in any domain, short or long term. HBS Basic Self-Direction Assistance (SDA): people with state-funded HBS may choose SDA to aid in the basic management of their personal support workers. (Paid for through Waiver Funding). Program Design: Support will be provided by a team and up to 5 times per week. Optional Personal Development Classes available to participants and other Members.

Utilization targets: 30 TPC, 18 NTPCs, 4 CSE, 2,063 SC, 2,878 Other (direct support hours + Personal Development class hours.)
Utilization result: 35 TPC, 14 NTPC, 12 CSE, 2,179 SC, 2,818 Other (2,550 direct support hours and 268 Personal Development class hours.)

Outcome 1a target: Families have an achievable long-term plan for community living.
Outcome 1a result: 80% of families with an ICS participant for >1 year report they have an achievable long-term plan. 100% of families with an ICS participant for <1 year report they are “working towards a plan.”
Outcome 1b target: Families spend less time providing daily living support.

Outcome 1b result: although challenging to gather data from the same respondents, 83% of families with an ICS participant for >1 year indicated that their support duties were "Quite Manageable." 17% indicated that this was "Somewhat Manageable."
Outcome 1c target: Families indicate an increase in quality of life.
Outcome 1c result: 67% indicated "Some Improvement" and 33% indicated "Somewhat" of an improvement.
Outcome 1d target: families indicate ICS supported their person to achieve desired goals.
Outcome 1d result: 100% of families with an ICS participant for >1 year indicated that ICS helped them achieve desired goals and 100% of families with an ICS participant for <1 year indicated that ICS support has increased independence skill at least "a little."
Outcome 2ai target: 95% of participants will maintain stable housing.
Outcome 2ai result: 95%.
Outcome 2aii target: 85% will express satisfaction with housing.
Outcome 2aii result: 95%.
Outcome 2aiii target: 50% will indicate the program helped with preferred housing.
Outcome 2aiii result: 50%.
Outcome 2bi target: 90% develop skills they identified as critical for community living.
Outcome 2bi result: 91% made progress in at least one goal, 42% in multiple goals.
Outcome 2bii target: 89% will indicate the program helped in skill building.
Outcome 2bii result: 90% of those completing checklist indicated program as helpful.
Outcome 2ci target: 90% will identify desire to build community connections (etc.)
Outcome 2ci result: 100%.
Outcome 2cii target: 80% will indicate the program helped build these connections.
Outcome 2cii result: 88%.
Outcome 2ciii target: 100% will have people and places where they are comfortable.
Outcome 2ciii result: 95%.
Outcome 3a target: 90% will increase Personal Outcome Measure scores in targeted outcomes.
Outcome 3a result: 55% of ICS participants for <1 year increased POM scores; 22% of ICS participants POM scores remained the same.
Outcome 3b target: 90% will increase POM Supports for targeted outcomes.
Outcome 3a result: 33% of ICS participants for < 1 year increased POM supports for targeted outcomes; 44% of ICS participants targeted support POM scores did not change.
Outcome 4 target: 100% will indicate growth/skill development based on course assessment.
Outcome 4 result: 93% indicated they learned new skills or improved skills.

DSC

Community Living *$628,000*

Services: Supports people to live their best life enjoying independence, community engagement, and self-sufficiency. Staff provide individualized training, support, and advocacy and assist people with independent living skills, health and wellness, community access, various financial supports, and technology. Emergency Response is available after hours and on the weekends.

Utilization targets: 78 TPC, 6 SC.
Utilization result: 76 TPC, 12 SC, 16,699 hours of service.

Outcome 1 target: 75% of participants will pass housekeeping and safety reviews at 80% or higher.
Outcome 1 result: 89%.
Outcome 2 target: 90% of participants will connect with community engagements.
Outcome 2 result: 89%.

Priority:
Personal Life

Community Choices

***Transportation Support** $243,000*

Services: Addresses barriers that many people with I/DD have in accessing and being engaged in the community. Transportation Coordination and Training: A dedicated staff person manages, schedules, and trains participants on the use of our transportation options as well as existing options (MTD, Uber, Lyft, etc) and the additional tools, technologies, and apps that can make those options safer and more accessible. Personalized Driver Services: CC drivers will be available from 8am-8pm on weekdays to provide scheduled rides to members according to their needs and preferences. Cost-free rides will be door to door with personalized reminders/arrival confirmations. Group rides will also be available for CC structured events.

Utilization targets: 45 NTPC, 3,256 SC, 4 CSE, 1,300 Other (hours of rides, scheduling, training, or support.)
Utilization result: 59 NTPC, 6,666 SC, 11 CSE, 2,886 Other (hours of rides, scheduling, training, or support.)

Outcome 1a target: 90% of participants will feel able to participate in life with family and friends.
Outcome 1a result: 82% said better with program support, 18% same, and 0% worse.
Outcome 1b target: 90% of participants will be able to maintain a job.
Outcome 1b result: 61% said better with program support, 39% same, 0% worse.
Outcome 1c target: 90% will be able to do things they are interested in.
Outcome 1c result: 94% said better with program support, 6% same, 0% worse.
Outcome 1d target: 90% will be able to take care of basic errands and needs.
Outcome 1c result: In error, this was omitted from the survey. Will be included in PY26.
Outcome 2a target: 80% will report increased confidence/comfort being in the community.
Outcome 2a result: 85% said this was better with program support, 15% same, and 0% worse.
Outcome 2b target: 80% will report increased confidence/comfort traveling in the community.
Outcome 2b result: 88% said better with program support, 12% same, 0% worse.
Outcome 2c target: 80% will report increased knowledge/confidence using technology related to transportation.
Outcome 2c result: 55% said better with program support, 45% same, 0% worse.
Outcome 2d target: 80% of families will report comfort with family members accessing community.
Outcome 2d result: not enough response from parents to provide good data on outcome.
Outcome 3a target: 90% will report increased quality of life after each month of use.
Outcome 3a result: 91% said better with program support, 3% same, 0% worse.
Outcome 3b target: 90% will report increased emotional wellbeing.
Outcome 3b result: 85% said better with program support, 15% same, 0% worse.
Outcome 3c target: 90% will report increased feeling in control of one's life.
Outcome 3c result: 85% said better with program support, 15% same, 0% worse.
Outcome 3d target: 90% will report increase in feeling respected and equal to others.
Outcome 3d result: 85% said better with program support, 15% same, 0% worse.

DSC

***Clinical Services** $263,000*

Services: Mental health and behavioral expertise to support people with I/DD. Counseling assessment and planning; individual, family, and group counseling; crisis response/intervention, short-term, long-term counseling. Initial/annual psychiatric assessment, quarterly medication review, and individual planning

consultation. Psychological assessment, including new prospective participants (eligibility determination) and for changes in level of functioning. DSC seeks clinicians and options beyond the consultants enlisted to support people seeking/receiving services. State funding is maximized prior to the use of county funding. Staff Support Specialist provides staff training and dedicated resources to improve behavioral support and enhance participant engagement.

Utilization targets: 65 TPC, 5 NTPC, 10 SC, 2 CSE.
Utilization result: 76 TPC, 7 NTPC, 33 SC, 2 CSE, 1,587 hours of service.

Outcome 1 target: 100% of counseling cases reviewed quarterly for progress and recommendations.
Outcome 1 result: 100%.
Outcome 2 target: 100% of psychiatric cases will be reviewed for progress and medication reduction.
Outcome 2 result: 100% reviewed. 5 patients had medication reductions.
Outcome 3 target: 80% positive ratings on self-assessment of services (increased well-being.)
Outcome 3 result: 82% of 17 returned surveys rated this positive impact.

DSC

Individual and Family Support *$320,000*

Services: Resource Coordinator supports families to have access to much needed services, as there is no age requirement to access this support. Financial support from CCDDB has afforded families to benefit from extended breaks through support such as traditional respite, CUSR camps, after-school programs, and summer camps with specialized supports. Other examples have included YMCA and fitness club memberships; overnight trips to conferences; social skills training; home modifications; and therapy/sensory/accessibility equipment not funded by insurance.

Utilization targets: 40 TPC, 20 NTPC, 8 SC, 3 CSE.
Utilization result: 43 TPC, 33 NTPC, 11 SC, 4 CSE, 8,043 hours of service.

Outcome 1 target: 20 will participate in educational opportunities and advocacy efforts.
Outcome 1 result: 33.
Outcome 2 target: 90% of families will express satisfaction with the service.
Outcome 2 result: 100%.

PACE

Consumer Control in Personal Support *$45,972*

Services: Personal Support Worker (PSW) recruitment and orientation, focused on Independent Living Philosophy, Consumer Control, and the tasks of being a PSW. Personal Assistant (PA)/PSW Registry can be sorted by; location, time of day, services needed, and other information which allows consumers to get the PSW that best matches their needs. Service is designed to ensure maximum potential in matching person with I/DD and PSW to work long-term towards achieving their respective goals.

Utilization targets: 30 NTPC, 250 SC, 20 CSE, 9 Other (Successful PSW matches).
Utilization result: 97 NTPC, 216 SC, 31 CSE, 4 Other.

Outcome 1 target: outreach through 20 CSEs.
Outcome 1 result: 25 outreaches.
Outcome 2 target: 250 contacts through CSEs or other.
Outcome 2 result: 216 contacts.

Outcome 3 target: 30 NTPCs.
Outcome 3 result: 34 PSWs (some NTPCs did not complete paperwork or did not pass background check.)
Outcome 4 target: 9 successful PSW matches.
Outcome 4 result: 4.

Priority:
Work Life

Community Choices

***Customized Employment** $256,000*

Services: Customized employment focuses on individualizing relationships between employees and employers resulting in mutually beneficial relationships. Discovery identifies strengths, needs and desires of people seeking employment. Job Matching identifies employers and learns about needs and meeting those needs through customized employment. Short-term Support develops accommodations, support, and provides limited job coaching. Long-term Support provides support to maintain and expand employment. Supported Experiences for First Time Job Seekers provides classroom and intensive job-shadowing at two local businesses in structured 12-week program for first-time job seekers and others seeking additional experiences.

Utilization targets: 50 TPC, 2,000 SC, 4 CSE, 3,020 Other (direct support hours/hours of service).
Utilization result: 54 TPC, 2,134 SC, 12 CSE, 3,162 Other (direct support hours/hours of service).

Outcome 1a target: 100% of participants will report engagement and support in employment process.
Outcome 1a result: engagement – 85% and support – 95%.
Outcome 1b target: 85% will report their strengths/interests are important to the employment process.
Outcome 1b result: 75%.
Outcome 2 target: 15 people will identify work interests/strengths in Discovery process (within 60 days.)
Outcome 2 result: 13 started and completed discovery, average wait list time = 64 days.
Outcome 3a target: 13 will work to obtain paid employment; 80% will find a job within 6 months.
Outcome 3a result: 7 found employment, average time 2.5 months; 100% found it within 6 months.
Outcome 3b target: 7 will work to obtain volunteer job or internship; 80% will find it within 6 months.
Outcome 3b result: 4 found volunteer positions; 100% found them within 6 mos.
Outcome 3c target: 100% of job matches related to person's employment themes.
Outcome 3c result: 100%.
Outcome 4 target: 20 will become independent at their jobs, through negotiation/coaching, within 2 months of their start date.
Outcome 4 result: 18 people used short term support. Average length of job coaching for new placements = 37 days.
Outcome 5 target: 70% will keep their jobs for at least one year.
Outcome 5 result: 75% of participants employed at the beginning of PY25 were still employed at the end of PY25.
Outcome 6a target: 100% of first-time job seekers increase knowledge/professionalism after 12 weeks.
Outcome 6a result: 70%.
Outcome 6b target: 80% will find community jobs within one year (if they choose it.)
Outcome 6b result: 67%.

DSC

Community Employment *$523,000*

Services: Assists people to find and maintain jobs. Discovery process: employment plan development; interviews with the person and others; daily observation; exploration of job interests; encourage/support volunteer opportunities; discussions of pre-employment habits. Resume or portfolio development: interview preparation and support; contact with potential employers; soft skills education and practice. Application process/follow-up: traditional and non-traditional approaches to interviewing/hiring. Job orientation, skill acquisition including transportation, mastery of specific job responsibilities, potential accommodations, adaptive tools, development of natural supports, foster relationship with supervisor and coworkers. Job coaching: advocacy, development of self-advocacy skills, identification of potential new responsibilities or promotions, monitoring work environment for potential risks to job security; identifying and facilitating natural supports. Supported Employment: establish volunteer/work options for all people; support to increase time management skills, communication, and work preparedness; support niches for a small group of people within local businesses. Employment Plus addresses work/social life balance. Planned get-togethers will function as a peer support forum for participants. Topics and activities will be driven by attendees.

Utilization targets: 88 TPC, 2 CSE, 10 SC.
Utilization result: 89 TPC, 2 CSE, 8 SC, 8,041 hours of service.

Outcome 1 target: 26 participants in job development.
Outcome 1 result: 25.
Outcome 2 target: 80% of participants will maintain employment.
Outcome 2 result: 84%.
Outcome 3 target: 90% of people who return surveys will express satisfaction with service.
Outcome 3 result: 100%.

DSC with Community Choices

Employment First *$102,500*

Services: Promotes a change in culture surrounding people with disabilities and their role and contribution to Champaign County as members of the workforce. Outreach and incentive for the business community promoting inclusion and prioritizing employment for people with disabilities. Directory of Disability-Inclusive Employers is a means of identifying employers who wish to hire qualified people with I/DD, a resource for those seeking employment, and a learning platform. Advocacy and ongoing dialogue with Division of Rehabilitation Services, Rotaries, Chambers of Commerce, and more.

Utilization targets: 25 CSE.
Utilization result: 29 CSE.

Outcome 1 target: 10 people will be hired by LEAP-trained businesses.
Outcome 1 result: 9 who were supported by DSC or Community Choices (other people may have found a job using the new Inclusive Employers website.)
Outcome 2 target: 80% of LEAP trainees will express satisfaction through survey.
Outcome 2 result: 100%.

Priority:
Community Life

Champaign County Regional Planning Commission Community Services

***Community Life Short Term Assistance** $232,033 (IDDSI Fund)*

Services: Provides financial assistance, along with supportive services to address needs and desires of furthering community life for adults with I/DD… [to] access social, developmental, and leisure activities, that may not otherwise be financially accessible… assisting individuals with I/DD toward further understanding, confidence building and longer-term self-sufficiency.

Utilization targets: 44 TPC, 88 NTPC, 25 SC, 8 CSE.
Utilization result: 5 TPC, 25 NTPC, 142 SC, 13 CSE, 491 hours of service.

Outcome 1 target: 90% of participants receiving financial assistance for technology purchases will report increased knowledge, skills, and ability to engage socially or entrepreneurially.
Outcome 1 result: 90%
Outcome 2 target: 80% of participants receiving financial assistance for payment of social events or classes will report increased knowledge, skills, ability to engage socially, or in overall wellbeing.
Outcome 2 result: 90%.

Community Choices

***Self-Determination Support** $228,000*

Services: Family Support & Education: educating families on the service system, helping them support each other, and advocating for improved services through public quarterly meetings and individual family consultation. Leadership & Self-Advocacy: 1 leadership class and Human Rights & Advocacy Group. Building Community: Structured Opportunities for adults with I/DD to explore their communities; Urban Explorers community opportunities with support from CC staff; Community Coaching: social skills development, tech training, interest exploration, individual and group connections. Cooperative Facilitation: management of resources to build cooperative communities, including member online platforms, individual membership connections, and the dissemination of coop news and opportunities.

Utilization targets: 215 NTPC, 3,369 SC, 4 CSE, 2,259 Other (direct support hours.)
Utilization result: 262 NTPC, 2,969 SC, 13 CSE, 3,749.5 Other (direct support hours.)

Outcome 1a target: 80% of family support group participants will indicate a strategy or resource learned or a connection increased after each meeting.
Outcome 1a result: 100%.
Outcome 1b target: Family members or adult participants will report higher rates of connection to other families.
Outcome 1b result: 100%
Outcome 1c target: 75% of family members engaged in programming will report greater knowledge of the service system, connection, and belonging in a supportive community.
Outcome 1c result: 77%
Outcome 2a target: 80% of leadership class participants indicate growth in leadership skills.
Outcome 2a result: 80%.
Outcome 2b target: Human Rights and Advocacy Group (HRA) members will identify areas to grow self-advocacy skills and rate their growth in those areas every 6 months.

Outcome 2b result: 100%.
Outcome 3a target: 75% of members with I/DD indicate the program provides them a supportive community (after a year.)
Outcome 3a result: 87%.
Outcome 3b target: 75% participating in structured activities will reach out to other members or initiate community engagement.
Outcome 3b result: 56%.
Outcome 3c target: 50% of members seeking community engagement will report or have an observed connection to people, groups, or places within 3 months.
Outcome 3c result: 50%.

DSC

Community First *$990,000*

Services: Community connection through participation in self-advocacy, recreational activities, social events, educational groups, volunteering, and other areas of interest to enhance personal fulfillment. Personalized support based on individual interests with choice identified through the personal plan, self-report, and surveys completed prior to the rotation of group offerings. Supports people with a wide range of interests, abilities, and needs, with people choosing from a diverse menu of activities, over 30 options.

Utilization targets: 45 TPC, 45 NTPC, 6 SC, 2 CSE.
Utilization result: 59 TPC, 134 NTPC, 13 SC, 2 CSE, 38,555 hours of service.

Outcome 1 target: 80% of participants will express satisfaction with chosen activities.
Outcome 1 result: 100%.
Outcome 2 target: 5 new groups based on participant feedback.
Outcome 2 result: 10.

DSC

Connections *$122,000*

Services: Community-based alternative encouraging personal exploration and participation in the arts/artistic expression, promoting life enrichment and alternative employment. Introduces and supports people to experience a creative outlet, promote self-expression, and profit from products they create/produce. Encourages people to be creative and offers a welcoming venue for a variety of events. Groups and classes vary and are based on the interests and requests of program participants. Program hosts on-site events to promote collaboration and a venue for like-minded community artists.

Utilization targets: 25 TPC, 12 NTPC, 5 CSE.
Utilization result: 38 TPC, 32 NTPC, 3 CSE, 2,525 hours of service.

Outcome 1 target: participants will host or engage in 5 events connecting with the community.
Outcome 1 result: 5 events.
Outcome 2 target: 90% of participants will express satisfaction regarding The Crow.
Outcome 2 result: Met, all participants were satisfied with their experience at The Crow.
Outcome 3 target: 2 collaborations with community artists teaching classes.
Outcome 3 result: 2 (pixel art and printmaking).

Priority:
Strengthening the I/DD Workforce

Community Choices

***Staff Recruitment and Retention** $48,000*

Services: Provides New Hire Bonuses to attract and hire well qualified staff in a timely manner; bonuses to all new employees who successfully complete training and 90 day probationary period; Retention Bonuses to retain high performing employees; current staff are eligible for a quarterly bonuses for maintaining their good-standing, active employment, including ongoing professional development applicable to each position.

Utilization targets: 16 NTPC, 3 CSE, 63 Other (sign-on & quarterly incentive payments.)
Utilization result: 19 NTPC, 5 CSE, 67 Other sign-on & quarterly incentive payments.)

Outcome 1 target: 100% of staff will be compensated at rates equal to or greater than those recommended in the Guidehouse rate study for DSPs ($19.50/hr., $40,560 annually).
Outcome 1 actual: 100%. Avg staff salary = $45,366, with a range of $42,500-$51,140.
Outcome 2 target: fill all open staff positions within 60 days.
Outcome 2 actual: all open positions were filled in an average of 34 days.
Outcome 3 target: average length of employee service greater than 4 years.
Outcome 3 actual: average of 4.1 years.

DSC

***Workforce Development and Retention** $244,000*

Services: Strengthens and stabilizes the workforce through training, support, and recognition/reward. Program utilizes trainings, resources, and tools for staff through NADSP membership. New employees will be provided hiring bonus after completing required agency training. Retention/incentive bonuses are paid to keep key employees during the workforce crisis and pandemic. Retention bonuses occur 3 times per year in recognition of staff enduring the challenges of a compromised work force and for the long-term effects of high turnover and frequent vacancies.

Utilization targets: 160 Other (DSPs receiving training and retention bonuses).
Utilization result: 544 Other (DSPs receiving training and retention bonuses).

Outcome 1 target: 1 training to support professional development.
Outcome 1 result: 3 NADSP trainings were offered (Frontline Supervisor Training, Leadership Training – Culture, Myths about Aging and the Developmental Disability Population).
Outcome 2 target: bonuses for 25 completing new employee training.
Outcome 2 result: 24.
Outcome 3 target: 140 employees will receive quarterly retention bonuses.
Outcome 3 result: 160 employees received 520 retention bonuses.

Priority:
Young Children and their Families: Collaboration with the Champaign County Mental Health Board (CCMHB)

Champaign County Regional Planning Commission Head Start/Early Head Start

Early Childhood Mental Health Services *$216,800 (CCMHB)*

Services: Addresses social-emotional concerns in the early childhood period and identifies developmental issues and risk. The social-emotional portion of the program focuses on aiding the development of self-regulation, problem solving skills, emotional literacy, empathy, and appropriate social skills. Accomplishments in these areas will affect a child's ability to play, love, learn and work within the home, school and other environments.

Utilization targets: 116 TPC, 380 NTPC, 5 CSE, 3,000 SC, 12 Other (workshops, trainings, professional development efforts with staff and parents).
Utilization result: 116 TPC, 62 NTPC, 3 CSE, 1,572.5 SC, 15 Other (workshops, trainings, professional development efforts with staff and parents), 557 hours of service.

Outcome 1 target: children will demonstrate improved social skills.
Outcome 1 result: 85% of children aged 6 weeks to 3 years were meeting or exceeding social emotional developmental expectations for their age group; 29% increase for those 3-5, and 31% increase for kindergarten bound. Overall, 73% of children in the program were meeting or exceeding social emotional developmental expectations for their age group.
Outcome 2 target: HS staff will demonstrate improved skills (interpersonal, stress management, and caregiving.)
Outcome 2 result: due to program and staff changes, the assessment tool was not given to teachers.
Outcome 3 target: parents will demonstrate improved skills (stress management and caregiving.)
Outcome 3 result: due to staff shortages and low family event attendance, the assessment tool was not given to parents.
Outcome 4 target: classroom management will demonstrate social-emotional sensitive interactions.
Outcome 4 result: 83% of classroom observations showed consistent, effective support/organization; the rest were effective in each domain but not always consistent.

DSC

Family Development *$702,000 (CCMHB)*

Services: Serves children birth to five years, with or at risk of developmental disabilities, and their families. Culturally responsive, innovative, evidence-based services. Early detection and prompt, appropriate intervention can improve developmental outcomes for children with delays and disabilities and children living in at-risk environments. Family-centered intervention maximizes the gifts and capacities of families to provide responsive intervention within familiar routines and environments.

Utilization targets: 655 TPC, 200 SC, 15 CSE.
Utilization result: 1,045 TPC, 186 SC, 16 CSE, 11,710 hours of service.

Outcome 1 target: 90% of caregivers will feel more competent/comfortable regarding their child's needs.
Outcome 1 result: 98%.
Outcome 2 target: 90% of children will progress in Individualized Family Service Plan (IFSP) goals.

Outcome 2 result: 91%.

CU Early

***CU Early** $16,145 (CCMHB)*

Services: Bilingual home visitor for at risk Spanish speaking families, serving expectant families and children up to age 3; completion of developmental screenings on all enrolled children alongside the parent to ensure that children are developing on track; referral to Early Intervention if there is a suspected disability or concern with the child's development.

Utilization targets: 20 TPC, 5 NTPC, 464 SC, 4 CSE.
Utilization result: 27 TPC, 7 NTPC, 714 SC, 17 CSE.

Outcome 1 target: 95% improvement in each area of parenting skill and knowledge.
Outcome 1 result: affection 100%, responsiveness 83%, encouragement 85%, and teaching 66%.
Outcome 2 target: 95% of children will make developmental progress.
Outcome 2 result: 92%. *NOTE: of bilingual caseload, 15 children on target, 3 with delays referred to EI, 8 received EI with an IFSP.*
Outcome 3 target: 95% of children up to date with well child exams and immunizations.
Outcome 3 result: 100%.

Briefing Memorandum on Input from Advocates

Date: March 25, 2026

To: Members, Champaign County Developmental Disabilities Board (CCDDB)

From: Lynn Canfield, Executive Director

Background

In November 2025, the CCDDB developed and approved a Resolution which asks other units of local government to improve accessibility and inclusion in our community. In January 2026, a list of action items was added as a Pledge other governments could make. We reached out to advocate groups who might have an interest in speaking to them, whether at council or board meetings or one on one, and who also might have responses to the proposed actions and related activities.

Pledge of Actions

Those actions include:

- Making it easier to find out about resources which are available to community members.
- Making sure those resources are available to and welcoming to people with I/DD or Autism.
- Including people with I/DD or Autism in making decisions which impact them.
- Creating accessible documents and websites and plain language documents.
- Raising community awareness of accessibility and disability issues.

Input from Advocates

Most advocates from DSC are less interested in attending council or board meetings than they are in making a video of themselves reading the pledge or speaking about inclusiveness and accessibility. Such a video would be presented to other units of government. One person might be ready for in person visits to governance meetings.

They also indicated that the park districts and mass transit district are respectful and offer opportunities for people with disabilities. If their governing boards do not include people with disabilities, or if they don't receive input from advocates or groups, that could be an area for improvement.

A small group from Community Choices have expressed interest in helping with this. They would like more direction on how they could support the project. A phone call with the staff person they work with or a zoom meeting might be the best place to start.

Next Steps

CCDDB staff request guidance from the Board, as all suggestions from advocates so far make sense but will require more collaboration.

A few small virtual meetings, to accommodate various schedules, could help shape the project and identify people who feel ready and interested in various activities.

A schedule of other governmental units' board or council meetings and a list of contacts for these entities will be very helpful. We can start close to home.

Champaign County Board

- Their Board meetings are held at 6:30 p.m. on the 3rd Thursdays following the 1st Mondays of each month: April 23, May 21, June 18, July 23, August 20, September 24, October 22, November 19, and December 17.
- The meetings are chaired by the County Executive, Steve Summers.
- To place an item on their agenda, contact Megan Robison at mrobison@champaigncountyil.gov by the 2nd Tuesday of the month.

- Their Committee of the Whole meetings are held at 6:30 p.m. on the 2nd Tuesdays following the 1st Mondays of each month: April 14, May 12, June 9, August 11, September 15, October 13, and November 10.
- The meetings are chaired by County Board Chair, Jennifer Locke.
- To place an item on their agenda, contact Megan Robison at mrobison@champaigncountyil.gov by the 1st Monday of the month.